REPORT OF THE ASSOCIATION OF ORTHOPAEDIC CHAIRMEN ON STATUS OF VA HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

SEPTEMBER 27, 1983

Printed for the use of the Committee on Veterans' Affairs

Serial No. 98-31

U.S. GOVERNMENT PRINTING OFFICE
27-316 O
WASHINGTON : 1983

H 761-6

COMMITTEE ON VETERANS' AFFAIRS

G. V. (SONNY) MONTGOMERY, Mississippi, *Chairman*

DON EDWARDS, California
BOB EDGAR, Pennsylvania
SAM B. HALL, Jr., Texas
DOUGLAS APPLEGATE, Ohio
MARVIN LEATH, Texas
RICHARD C. SHELBY, Alabama
DAN MICA, Florida
THOMAS A. DASCHLE, South Dakota
WAYNE DOWDY, Mississippi
MATTHEW G. MARTINEZ, California
LANE EVANS, Illinois
MARCY KAPTUR, Ohio
FRANK HARRISON, Pennsylvania
ALAN B. MOLLOHAN, West Virginia
TIMOTHY J. PENNY, Minnesota
HARLEY O. STAGGERS, Jr., West Virginia
J. ROY ROWLAND, Georgia
JIM SLATTERY, Kansas
JOHN BRYANT, Texas
BILL RICHARDSON, New Mexico

JOHN PAUL HAMMERSCHMIDT, Arkansas
CHALMERS P. WYLIE, Ohio
ELWOOD HILLIS, Indiana
GERALD B. H. SOLOMON, New York
BOB McEWEN, Ohio
CHRISTOPHER H. SMITH, New Jersey
DENNY SMITH, Oregon
PHIL GRAMM, Texas
DAN BURTON, Indiana
DON SUNDQUIST, Tennessee
MICHAEL BILIRAKIS, Florida
NANCY LEE JOHNSON, Connecticut

Mack Fleming, *Chief Counsel and Staff Director*

Subcommittee on Oversight and Investigations

G. V. (SONNY) MONTGOMERY, Mississippi, *Chairman*

DON EDWARDS, California
SAM B. HALL, Jr., Texas
TIMOTHY J. PENNY, Minnesota
HARLEY O. STAGGERS, Jr., West Virginia
J. ROY ROWLAND, Georgia
LANE EVANS, Illinois

ELWOOD HILLIS, Indiana
GERALD B. H. SOLOMON, New York
DAN BURTON, Indiana
DON SUNDQUIST, Tennessee
NANCY LEE JOHNSON, Connecticut

CONTENTS

SEPTEMBER 27, 1983

Page

Report of the Association of Orthopaedic Chairmen on the Status of VA Health Care 1

STATEMENTS OF COMMITTEE MEMBERS

Chairman Montgomery 1

Hon. Don Sundquist 2

WITNESSES

Brown, D. Earl, Jr., M.D., Associate Deputy Chief Medical Director, Veterans' Administration, accompanied by Ralph Ibson, Deputy Assistant General Counsel; Ernest Burgess, M.D., member, Special Medical Advisory Group; Carl W. Hughes, M.D., Assistant Chief Medical Director for Professional Services; and Robert C. Laning, M.D., Director of Surgical Service, VA Central Office 19

- Prepared statement of Dr. Brown 80

Evarts, C. McCollister, M.D., president, Association of Orthopaedic Chairmen; James Hughes, M.D., Chairman, Committee on Veterans Affairs, Association of Orthopaedic Chairmen, accompanied by Harlan Amstutz, M.D., president-elect, AOC; Wilton H. Bunch, M.D., secretary-treasurer, AOC; Joseph Kopta, M.D. and Vert Mooney, M.D., members of the Executive Committee, AOC 3

- Prepared statement of Dr. Evarts 78

Kenmore, Peter I., M.D., professor and chairman of orthopaedic surgery, Georgetown University School of Medicine, Washington, D.C 27

- Prepared statement of Dr. Kenmore 91

Schafer, Paul W., M.D., Executive Director, National Association of VA Physicians 30

- Prepared statement of Dr. Schafer 93

MATERIAL SUBMITTED FOR THE RECORD

Reports:

- Committee on Veterans Affairs of the Association of Orthopaedic Chairmen 41
- VA reply to the report of the Association of Orthopaedic Chairmen 70

Statements:

- Disabled American Veterans 98
- Dr. Charles A. Rockwood, Jr., chairman, Department of Orthopaedics, University of Texas Medical School, San Antonio, Tex 101
- The American Legion 105

Written committee questions and their response:

- Hon. Elwood Hillis to Veterans' Administration 85

REPORT OF THE ASSOCIATION OF ORTHOPAEDIC CHAIRMEN OF THE STATUS OF VA HEALTH CARE

TUESDAY, SEPTEMBER 27, 1983

House of Representatives,
Subcommittee on Oversight and Investigations,
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met, pursuant to notice, at 8:30 a.m., in room 334, Cannon House Office Building, Hon. G. V. (Sonny) Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Hall, Penny, Rowland, Sundquist, and Johnson.

Also present: Representative Dowdy.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. Montgomery. The subcommittee will come to order.

This morning we are meeting to hear testimony on a report prepared by the Veterans' Affairs Committee of the Association of Orthopaedic Chairmen. The report was issued earlier this summer from Jackson, Miss., and it contained some disturbing allegations about the delivery of health care in the Veterans' Administration, especially in the field of orthopaedic care.

Dr. Hughes, the author of this report, says that while "there is within the VA system a substantial quantity of quality health care in the VA, there is an increasing deterioration of medical care which, if not reversed, could jeopardize the entire program."

If these charges are accurate, we owe it to our veteran population to get to the bottom of the deficiencies and correct them. If they do not reflect a trend of deterioration, we must reassure our veterans that medical care in the Veterans' Administration is still second to none.

The subcommittee has invited a group of witnesses who we believe will be able to provide us with great insight into the health care practices of the Veterans' Administration. We will hear from representatives of the Association of Orthopaedic Chairmen, the Veterans' Administration, several chairmen of departments of orthopedics in affiliated medical schools, and the National Association of VA Physicians.

At this time the Chair would like to recognize our minority member on the subcommittee, Congressman Don Sundquist of Tennessee, for any remarks he would like to make.

STATEMENT OF HON. DON SUNDQUIST, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mr. SUNDQUIST. Thank you, Mr. Chairman.

I want to begin by thanking all those who have taken time from a busy schedule to be here this morning to testify before this subcommittee. The report that prompted this hearing has caused me great concern also, Mr. Chairman. I am anxious to hear what the witnesses have to say about it.

I know there are always problems anywhere, and there are problems within the VA hospitals, but we need to get the facts on the issue. If what the report says is true, then this committee and the VA should be quick to work for remedies. If not, then we ought to clear up any misunderstanding so that we can reassure our veterans that they are getting topnotch health care. So I look forward to the testimony this morning and again I thank everyone for being here.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. I see that our first witnesses are at the table. Before hearing from these witnesses, I would like to recognize Congressman Wayne Dowdy from my State for any comments he would like to make. He is not on this subcommittee but he is a member of the full Veterans' Affairs Committee.

Mr. DOWDY. Thank you, Mr. Chairman. I have no comments, other than to thank you for allowing me to be present for this subcommittee hearing.

Mr. MONTGOMERY. Mr. Dowdy is on the Compensation and Pension Subcommittee as well as the Hospital and Health Care Subcommittee. The chairman of that subcommittee will be here this morning.

Also before recognizing the witnesses I want the record to show that our good friend, and a good friend of mine, is here today, Mr. Bill Spell, an attorney from Jackson, Miss., who helped write part of this report and also worked on the Hill for several years with senior Senator John Stennis. I would like to welcome Mr. Spell.

Mr. MONTGOMERY. The Chair recognizes Dr. Evarts, and you might introduce the other witnesses with you this morning, Dr. Evarts. Dr. Evarts is president of the Association of Orthopaedic Chairmen, and Dr. James Hughes, chairman of the Committee on Veterans' Affairs, Association of Orthopaedic Chairmen.

Dr. Evarts, you might want to start, since you are the president of this Association, and you may proceed in any manner that you would like.

STATEMENTS OF C. McCOLLISTER EVARTS, M.D., PRESIDENT, ASSOCIATION OF ORTHOPAEDIC CHAIRMEN; JAMES HUGHES, M.D., CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS, ASSOCIATION OF ORTHOPAEDIC CHAIRMEN, ACCOMPANIED BY HARLAN AMSTUTZ, M.D., PRESIDENT-ELECT, AOC; WILTON H. BUNCH, M.D., SECRETARY-TREASURER, AOC; JOSEPH KOPTA, M.D. AND VERT MOONEY, M.D., MEMBERS OF THE EXECUTIVE COMMITTEE, AOC

STATEMENT OF C. McCOLLISTER EVARTS, M.D.

Dr. EVARTS. Thank you very much, Mr. Chairman, members of the subcommittee, and others.

We certainly appreciate the opportunity to attend and participate in the hearing on the report prepared by Dr. James Hughes in regards to the VA's health care procedures, policies and practices.

The Association of Orthopaedic Chairmen feels a responsibility to clarify the record about the report. Although Dr. Hughes is chairman of the subcommittee, our Subcommittee on Veterans' Affairs of the Association of Orthopaedic Chairmen, and has long been interested in veterans affairs, this report was not reviewed and approved by the executive committee of our organization prior to its release. Nevertheless, Dr. Harlan Amstutz, who is president-elect of our organization, and professor and chairman of the Division of Orthopaedic Surgery from the University of California Medical Center, Dr. Wilton Bunch, who is secretary-treasurer of the organization and professor and chairman of the Department of Orthopaedic Rehabilitation at Loyola, Dr. Joseph Kopta, who is a member of the executive committee of the Association of Orthopaedic Chairmen and professor and chairman of the Department of Orthopaedic Surgery and Rehabilitation at the University of Oklahoma, and Dr. Vert Mooney, who is professor and chairman of the Division of Orthopaedic Surgery at the University of Texas at Dallas, these gentlemen, along with myself, represent five of the eight executive committee members of the Association of Orthopaedic Chairmen and are all present today in support of this report.

In studying its contents, there are issues which are common to many types of medical services and hospitals, including the Veterans' Administration hospitals, involving difficulties with budgets, supplies and administration—all of which, of course, ultimately impact on patient care. It was obvious from studying the report, however anecdotal the report might be, that frustrations were seriously felt by the providers of orthopaedic services due in part to a current breakdown of communication in some selected situations.

In the past, the Association of Orthopaedic Chairmen has worked with the medical staff in the central office of the VA, and looks forward to working with them again to improve communications.

It is important that the problems facing the providers of orthopaedic care continue to be reviewed and discussed with the ultimate goal of better care for the musculoskeletal patient within the veterans' population.

Others will testify this morning. We certainly appreciate the opportunity of appearing and I, as well as other members of the executive committee who are here today, would like the opportunity to respond following the others' testimony.

I think Dr. Hughes will be following me in the morning's session. Thank you.

Mr. MONTGOMERY. Thank you very much.

We will try to do what you ask. We have a time factor. We are having a Democratic caucus on the War Powers Act this morning and we have other matters pending, but we will have ample time to air this situation and try to come up with some reasonable answers on this report.

The Chair would like to recognize Dr. Hughes now. If you would like to summarize your report—and any other witneses this morning may do the same—that would help the Chair. Your complete statement will be put in the record. You may proceed in any manner that you so desire.

STATEMENT OF JAMES HUGHES, M.D.

Dr. HUGHES. Thank you, Mr. Chairman, members of the committee, Mr. Dowdy. On behalf of the physicians who have contributed to this report, I express the appreciation of all of us for the opportunity to be heard today.

Each physician in our organization vigorously supports the commitment our Nation has made to its veterans. As physicians, we feel we have a unique and special duty to speak out candidly and responsibly regarding medical care provided to veterans in Veterans' Administration hospitals where we share the responsibility for patient care. Our ultimate and single purpose is to provide quality medical care for the VA patients.

This study and its findings are submitted to you in the hope that you will listen and respond. We need your people and the American veterans need your help.

This report, its critical tone notwithstanding, is given to you in a spirit of helpfulness and out of a sense of loyalty to our patients. Unfortunately, some in the Veterans' Administration management apparently have allowed their dissatisfaction with the report to obscure recognition of the purpose, substance and spirit of its contents. Almost all of the criticism has been directed to those who made it or the methodology used. We have yet to hear these critics respond to the substance of our findings with positive and constructive recommendations of how the deficiencies we have identified can be eliminated.

The report, indeed, Mr. Chairman, has been provided, and we ask that it be printed in the record.[1] The substance of our effort is contained in the six findings, which are as follows:

No. 1, veterans, many in pain and with service-connected illnesses, are routinely denied treatment for long periods for lack of medical funds, while nonmedical and much less essential expenditures continue. Lawn sprinklers, earthquake proofing and similar items often are priority over artificial hips, surgical instruments, and prescription drugs.

No. 2, accomplishment of medical procedures, particularly those related to surgery, are made less effective and sometimes are severely compromised by the imposition of employment contract provisions forced on the VA by labor organizations or voluntarily adopted by VA management.

---

[1] See p. 41.

No. 3, the risk of surgery to patients is often significantly increased because surgical instruments malfunction, are lost, lack essential components, or are poorly maintained.

No. 4, the length of the VA patient's hospital stay and the circumstances under which medical treatment is delivered is quite frequently determined by administrative and budget requirements rather than by standards of good medical practice. Compliance with VA administrative and budgetary requirements often violate the standards of good medical practice and result in higher costs and inferior medical care.

No. 5, the standards of good medical practice are so grossly abandoned in some VA hospitals that young, conscientious physicians and other health care professionals are becoming so frustrated that they prefer to work elsewhere. As the competent, dedicated physicians and health care professionals leave the system, they are replaced by persons of perhaps less dedication and competence and the deterioration of health care is accelerated.

No. 6, the operation of the VA hospital system is dominated by administrators whose bureaucratic philosophy and procedures conflict so sharply with the efficient, effective delivery of medical care that veterans, in many instances, receive substandard medical care, administratively delayed care, or, on occasions, no care at all. Some of these administrators are physicians who have deserted the basic and essential concepts of clinical medical practice and have become defenders and advocates of the system that has diminished greatly and, in some cases, totally abandoned good clinical standards.

It has been suggested by some, Mr. Chairman, in the VA management that our report represents the view of a few uninformed prima donna orthopedists whose real purpose is to elevate their hospital service to the status of a department. Let me assure the committee that our objective is to improve medical care to veterans, not obtain departmental status for ourselves.

Giving orthopedists a one-level step up in the multilayered administrative VA structure would be comparable to raising one buried under 100 feet of earth 10 feet closer to the surface. The result is the same. Upward movement is limited and patient care overall may not be improved.

In preparing for this hearing, VA authorities have made an extensive effort to solicit favorable comments on VA medical care from physicians who work within the VA system. This effort was especially strong among orthopedists and some have stated that the VA system of health care is indeed sound.

We are quick to say that when all VA facilities are operated at a high level and standard, as some have said, we also would give our endorsement to that system. Our report acknowledged that many veterans received good medical care.

The report stated—and you read part of it in your opening statement—

> The fact that there is within the VA system a substantial quantity of quality health care does not excuse an increasing deterioration of medical care which, if not reversed, could jeopardize the entire program. It is also not within the conscience of

> the participants within this study to excuse any failure to meet the standards of medical care for any person for whose treatment the physicians are responsible, particularly if the patient is one who has faithfully served in the military defense of our Nation.

Our study was deliberately designed not to praise what is good about the VA health care system but to determine the practices and conditions that are unacceptable and to discover how that which is unacceptable could be improved and made more cost effective. It seems to us that this purpose should be consistent with the charter and responsibility of your committee, the Congress, and the Veterans' Administration.

We come before you, Mr. Chairman, submitting our report along with a request that we would like for you to consider. We suggest that you encourage the establishment of a working committee consisting of the medical director of the Veterans' Administration and appointees of his selection, members of your committee or designees of your choice, and members of the Association of Orthopaedic Chairmen, to meet quarterly for an exchange of views regarding VA medical care. From this committee, recommendations could be made that would benefit all those affected by VA medical care, particularly the veteran patient.

Mr. Chairman, before releasing the microphone, I would like to take this opportunity to comment on several things, particularly as relates to some of the reports that may be given later this morning. We have had the privilege of looking at Dr. Brown's report that will be given later on and would like to make three statements, and perhaps have some of the members present with me comment.

The statement alluded to the fact that the VA had no opportunity to have input into this report. We would like to state, Mr. Chairman, for the record that on June 8, 1983, a copy of this report was made available to the subcommittee 4 weeks prior to the time that it was given even to the executive committee. In the presentation I stated:

> This advance copy of the report is being sent to you before it is sent to the AOC members so that you may have a few days to look it over and make such comments or take such actions as you might wish. Distribution to participating members of the AOC will be made in early July. If you have any comments or suggestions prior to that date, please let me know. It is our desire to work with you in order that together we may reach what I am sure is our mutual goal, that of quality medical care for the veterans.

We did not receive any response prior to the release in early July.

The second consideration that I would like to place before you has to do with the questionnaire that was circulated in the VA system in regard to some of the considerations or substance that we have raised. I did not personally see a copy coming through our VA chain of the questionnaire that came through. It makes me question, Mr. Chairman, how many of the orthopedic people actually had an input into the questionnaire that was given. Did it stop with the chief of surgery of the Administration, or did it, in fact, filter down. Obviously, some did go to the orthopedists in the VA system. I think Dr. Bunch and Dr. Kopta would perhaps be able to comment on those two situations.

Dr. **Kopta**. Mr. Chairman, for the past 9 years I have been the chairman of orthopedic surgery at the University of Oklahoma, and during that period of time I have had three faculty members who served as chiefs of service at the Veterans' Administration. Two have left in frustration, and the third has requested that he be replaced as the chief of service at the VA, after being there for almost 3 years.

The frustrating things are those that are contained in the report. When our director called me about this, he wanted to know if, indeed, those things happened at our local VA and was really not aware that, indeed, they are happening every day.

The system doesn't function at the local level. We have tried time and time again to get changes brought about, but nothing happens. We are still facing a 30-percent cancellation rate on our surgeries, with veterans having no advance notification. We still have maintenance problems as far as instruments are concerned and not enough supplies to do the type of work that we feel is justified.

In regards to——

Mr. MONTGOMERY. Which hospital is that?

Dr. KOPTA. The University of Oklahoma, the Veterans' Administration hospital in Oklahoma City.

The report that was circulated in the form of a questionnaire by the Veterans' Administration was filled out by our chief of service, but after filling it out he received several calls from members of the administrative structure in the form of harrassment, I would term them. As far as his answers were concerned, he did not want to pass those along, and I don't know whether or not they were passed along.

Thank you.

Mr. MONTGOMERY. You might identify yourselves for the record.

STATEMENT OF WILTON H. BUNCH, M.D.

Dr. BUNCH. Mr. Chairman, I am Wilton Bunch. I have been chairman at Loyola for 8½ years and, as such, have been associated with Hines VA.

We, too, have had three Chiefs of Service in that period of time, two of which left in frustration with the system and their inability to deliver what they considered to be the quality of care that they were able to provide their patients elsewhere.

With regards to the report, the report was filled out by our present Chief of Service. However, when it was turned in, the Associate Chief of Surgery looked at the various answers and said, "Oh, we can't send those in. Why, that would look bad. We can't send that answer in, that would look bad. Oh, that answer can't be sent in." I don't know what was sent in, but I do know that the report, as we presented it, was considered unacceptable.

We, too, have tried very hard to work at the local level. The report and the testimony by Dr. Brown suggests that this is the answer to the problems in this. I believe every one of us have tried to do this for years and have found that we are unable to make it work. I believe that this is highly variable, so that Dr. Rockwood's installation may work very well. In our discussions this morning, Dr. Amstutz is able to have approximately three times the staff at the VA hospital to deal with a patient load approximately equal to ours, and yet we run on a third of what he has, thus again indicating tremendous local variances.

So we come not saying that everything applies to every installation, but certainly there are problems that local work seems unable to deal with, and the result is that in those areas where the local conditions cannot be changed, we feel the care is severely impaired and substantially below what we can deliver elsewhere.

Dr. HUGHES. The third point, Mr. Chairman, as has already been addressed by these two witnesses, basically has to do with the fact that it is difficult to work out things at a local level. Dr. Amstutz can perhaps comment briefly on this. I would like to say that in writing the letters to the colleagues, as to the difficulties involved in working in the VA system, one individual tried for approximately 8 years to accomplish something on a local level; 1½ years, when he was a chief of orthopedic service in a hospital, he wrote memos to his chief of staff and he did not get a single reply to a memo for 1½ years that he sent in.

Dr. Amstutz?

STATEMENT OF HARLAN AMSTUTZ, M.D.

Dr. AMSTUTZ. I am Dr. Amstutz, chairman of orthopedics at UCLA, and have been a senior consultant at the Wadsworth Station for 12 years, and for the last 6 years have been chief of the section. I was asked to assume that role because of the problems of attracting quality individuals to run that section.

During the past 6 years we have made some improvements by utilizing faculty jointly with UCLA, which is adjacent and across the street. I have worked very diligently and hard with our hospital administrator, our chief of staff, Earl Gordon, and chief of surgery, Ed Pissaro, to try to correct many of the deficiencies that were in this report.

I did not submit a report. It is not part of or 1 of the 33 institutions. The report that I was getting together was going to try to make some comparisons, and it is still an ongoing little study, between the problems that we have at the VA in providing what we think is the best possible care and comparable to that which we provide at the medical center. But as I say, much of what is contained in the report applies to our institution.

Before coming here, I touched base with my seniors at the institution, and they are very supportive. They would like also to see improvements. For example, we have 40 unfilled positions at the GS-4 level. These are secretarial and support personnel. We're in an area which has a high cost of living. You cannot recruit competitively with private industry and other commercial organizations for any kind of quality at that level. You get practically persons who are grossly deficient.

The same is true all up and down the personnel structure. We simply do not have quality individuals to assist us in taking care of the veteran patients. This leads us to problems of breakdowns in the operating room, not adequate X-rays. You essentially can't schedule an emergency operation at night if you need an X-ray, because you won't have a quality technician to take that X-ray. So you, in a sense, delay the surgery until the next day, even though this may not be in the best interest of the patient from an optimal standpoint, but just because you can't get a quality X-ray.

I have diligently tried to work with our chief of staff and with the hospital administrator. They are sympathetic to our wishing to improve the care of the veterans to be able to cut some of the bureaucratic redtape and to make changes necessary so that we can get quality personnel within the system to take care of the veterans.

Mr. MONTGOMERY. We're having time problems, and the red light is on. But, Doctor, I was just out in Wadsworth and I met with the administrator, the chief of medical services, and the report was out there. Quite frankly, I asked him to tell me if they saw that much merit in the Hughes' report. Very frankly, I didn't get the same answers that you are telling us this morning.

Why didn't they tell me? I was there. Now you're telling me they are really not satisfied at Wadsworth, that there is a shortage of personnel and the orthopedic services are not good. Is that what you're saying?

Dr. AMSTUTZ. Well, you were there, and you did tell me you were there. When I went up and talked to him before coming here, I think he was feeling sensitive, that perhaps we were attacking—or that maybe I was a part of that report. By working with him, we have accomplished a lot of objectives. But it has been by using the medical center's resources, so to speak—In other words, we get our typing, we get our things done over at the Center for Health Sciences for the VA patients. We can't get it done at the VA. We have to take it over there, and essentially we get it done because we have the VA patients' health very much at our heart. He doesn't appreciate—well, he does know that, now that I have talked to him, after you had left, and he said, "Well, if there's a message, please give this message to Mr. Montgomery because he has just been here."

Mr. MONTGOMERY. Well, there is no reason for us to go out if they aren't going to tell us what's wrong. We're wasting a lot of taxpayers' money if they're not going to tell us what the problems are. I hope we can come up with a clear picture of what's really happening out there.

Are those all of your comments? We want to move on if we can and let Members ask some questions.

Dr. HUGHES. Only one other comment, sir, and then I certainly would release it to answer any questions you may have.

I had the privilege of reading Dr. Schafer's report this morning, and I don't think any of us could comment on the organization he represents. But I have some concern about the facts as representing this report that he stated, as to the accuracy of them.

Thank you.

[The report of the Association of Orthopedic Chairmen appears at p. 41.]

Mr. MONTGOMERY. Thank you.

The Chair will implement the 5-minute rule, and since I have become involved in this report, I believe I will take my 5 minutes now as chairman of the subcommittee.

Dr. Evarts, I think we need to clear up how this report was issued. I think maybe I have more problems with the way that was handled than anything else.

As I understand it, the report was not submitted to you for your approval; is that correct?

Dr. **Evarts**. No, that's not correct. The report was submitted to us for our approval and the executive committee, at the time of the release of the report, hadn't completed its review of the report. The executive committee's concerns with the report are more of form rather than function.

Mr. **Montgomery**. When did you approve of the report?

Dr. **Evarts**. We have five of the eight executive committee members here now, and although it has not formally been approved, I suspect that approval will be forthcoming.

Mr. **Montgomery**. But there was a press release in Jackson, Miss., the first of July releasing the report. I guess I'm saying I just wish that press release had been delayed or been approved by your chairmen's group. Also, I did receive a letter from Dr. Hughes and I shot the letter and the report up to Dr. Custis at the VA for any comments. Before I could get any comments back, the release was made.

I would have preferred, since I am chairman of this committee, and this was released in my home State, that I at least had the chance to answer before the report was released. So, in effect, it just put us on the defense. If we had had a chance for some input, then we might have had a little better idea of what was going on.

Dr. **Evarts**. Mr. Chairman, I think I can understand your dilemma. We're talking about communication this morning and I would admit that we had a bit of breakdown of communications within our own organization, as small as it might be.

Mr. **Montgomery**. It's pretty large, when you hadn't even approved the report yet, and here we are having a hearing on it.

Dr. **Evarts**. I'm not certain one could make that assumption. I think we are seeing a universal and wide support of the report. Again, I can't tell you that we are absolutely going to formally approve it. And yet in spirit, and in the form of what the report says—not the dotted i's and the way it is written—that was the main concern of the executive committee members.

Remember, they all reserve the right for editorial change and that was not accomplished. I don't want to take away from the impact of the report.

Mr. **Montgomery**. I won't dwell on it, but your letter does say, "This report was not reviewed and approved by the executive committee of the AOC prior to its release."

Dr. **Evarts**. That's correct.

Mr. **Montgomery**. Dr. Hughes, I'm a little concerned about your first finding, where you say the VA is more worried about lawn sprinklers and other cosmetics than it is about hip balls and other equipment that is needed to move ahead such as artificial hips, surgical instruments, and prescription drugs.

Tell us what is behind that finding.

Dr. **Hughes**. Mr. Chairman, I wouldn't personally use the words the VA is more concerned about lawn sprinklers than hip joints. What happens on the budgetary line is, in many institutions which are reflected in this report, the money is not present sometimes on a quarterly basis to buy the prosthetic components that the veterans need. Therefore, we, as surgeons, do not have the capacity to put them in place in the patients. This is, at the same time, because of the way budgetary things are handled.

In other words, the maintenance of the hospital itself has its budgetary line. At that point, there is no way to transfer over from one structural unit of money to the other unit. In other words, the things that are thought to be necessary for the VA maintenance goes on, and yet the patients, after we see them, we have to say, "Look, we have to put you on a list," and so forth, and they go across and moneys are being spent elsewhere. So I wouldn't say there is no concern about that. It simply has to do with the way things are handled on a budgetary way.

Mr. **Montgomery**. My time is up. I would only ask this one question.

Can you tell us how you went about gathering this information? What was the methodology and design used in writing this report?

Dr. **Hughes**. Thank you, Mr. Chairman, for that question.

We have been interested for the greater part of 4 years in terms of this problem. The basic question before us was how can we impact change in regards to the VA system of doing things? We noted that the National Academy of Science—and I would not purport to be an expert on that report of 1977—but I had to ask the question, "How have things changed as a result of that report on the VA?"

We launched out, Mr. Chairman, with $7,000 of our own money to work out a systems-methodological approach on the VA system. This is a copy of the first draft of that report. You are certainly welcome to it, you and your subcommittee.

We did not feel that report would accomplish what we wanted to do, and that is, impact change for our patients. We took the route, Mr. Chairman, of a case report kind of reporting, which is a valid way of medically documenting something. I simply wrote each of the colleagues in the AOC and said,

> Gentlemen, if you have things that impede your ability to give medical care, quality medical care, in the VA system, I would like for you to document it, and it needs to be related to patient's name, rank and serial number.

In that regard, Mr. Chairman, two things could have happened. No. 1, nobody could have written me back; therefore, there would be no report. As a matter of fact, people did write back, and that forms the basis of the report. I did not change a single word in any of the report. All we did was assimilate the letters and that forms the form of the report.

In case history reporting, Mr. Chairman, if you see a trend that is indicative of some generic problem within the system, that's the methodology.

Mr. **Montgomery**. Some did not want their names used; is that correct? They indicated this in the letters they wrote you?

Dr. **Hughes**. We told them, Mr. Chairman, that we would protect their confidentiality. I can assure you that they are valid AOC chairmen. We have in our possession those letters. But we recommended confidentiality because of some of the difficulties in terms of harassment and so forth that can go on at a local level, as has been alluded to in previous testimony this morning.

Mr. **Montgomery**. Mr. Sundquist.

Mr. **Sundquist**. Thank you, Mr. Chairman.

I think one of the points you make, and rightfully so, I suspect, is the fact that there is poor communications within the VA hospital network. I would reflect for just a minute on what the chairman said, and that is, when you communicate poorly, you do your cause harm. In the non-orderly fashion that you proceeded, by apparently seeking press first as opposed to seeking facts from this committee, I think you do some damage to what essentialy has raised some good points. Notwithstanding, I would like to ask a couple of questions.

First of all, since this report has come out, have you had any pressure, or have any of your physicians had any pressure from the VA, any criticisms, anybody trying to do anybody in as a result of this?

Dr. **Hughes**. Personally—I am aware of pressure. Has any come on me in a personal way? Only my natural tendency to be concerned to appear before a group like you, which is not normal for me. But as far as the pressure, somebody saying "Hughes, we're going to get you", and so forth, the answer is absolutely not. But I can, Mr. Sundquist, document the fact that there has been pressure from the VA officials put on some of the American Academy of Surgeons—I won't say pressure, per se, but obviously communication. I think Dr. Kopta related to the fact, and Dr. Bunch related to the fact, that there is some concern at that level.

Mr. **Sundquist**. I hope you will let us know if there are any major problems as a result of this being done.

Dr. **Hughes**. Mr. Sundquist, may I just say one comment to your opening statement, about the methodology on how we released it?

I did not personally release this statement. After it was sent to the press, I have not talked to them, except the newspaper person who called me up——

Mr. **Sundquist**. Who sent it to the press?

Dr. **Hughes**. I do not know that particularly, Mr. Sundquist, simply because after we released it for 3 to 4 weeks, and released it to the other people, we also released it to several other ranking officials here on the Hill. At that point, after the dissemination, the newspaper got hold of it. I did not personally call them into my office and say "I would like to release this." So once it is disseminated, it was out of the control that I had.

Mr. **Sundquist**. You have no idea who released it?

Dr. **Hughes**. No, sir.

Mr. **Sundquist**. My question involves page 2 of the report, where it states, "The Orthopaedic Chairmen study confirmed that surgical beds are often occupied by patients who are not candidates for surgery or who are discharged without surgery." Then a followup to that, on page 15, there is a statement—and perhaps these are not related, but I suspect they are—"The services should be rewarded for a low bed census and a fast turnover rate rather than having somebody sit around needlessly to keep beds full and increase hospital census."

Is there a relationship between those two statements, and would you comment on that?

Dr. Hughes. There probably is. Perhaps Dr. Mooney could comment on that.

Dr. Mooney. I am Dr. Vert Mooney from Dallas.

In the statement about VA care second to none, this is worthy of comparison to other institutions functioning on the same sort of patient population. The rest of the medical care in other hospitals is done by and compensated on the level of the time the patient is in for the disease, not how many beds are filled.

If our rewards are based on the number of beds filled, inefficiencies without question proceed at a much higher rate. Every VA sees this problem, that the beds are kept filled because if the beds are not kept filled then rewards in terms of numbers of patients, numbers of nurses, and that sort of thing are not supplied. But that is one of the cores of inefficiencies and that is where that particular response came from.

Mr. Sundquist. I guess my question is this: Is it a widespread practice of VA to put nonsurgical patients in beds that then delays surgical patients?

Dr. Mooney. It is a standard procedure to keep the beds filled by whatever maneuver is available.

Mr. Sundquist. Does that result then in someone not getting surgery when they should get surgery, because there is not a bed?

Dr. Mooney. In some cases, that occurs.

Mr. Sundquist. Another question. In terms of your recommendations on the last page, what would you do? I know it's a very complicated question, and you have most of your report on what the problem is and only one page and two comments on what ought to happen. Let me rephrase it because I'm out of time.

Do you intend to submit to us the detail of your recommendations as to how it ought to be redesigned and restructured?

Dr. Hughes. Yes; given an appropriate amount of time, we could. We felt that would emerge in the improved communication if you, Mr. Chairman, would allow our suggestion this morning and recommendation to be carried out, that that could be the format in which we could sit down with the gentlemen at the VACO and simply outline to them what our concepts are in terms of what we feel should be accomplished. It is obviously a systems-methodological kind of consideration and we certainly would take that time with members of your staff, or whoever the chairman appoints, to be there to see this. So we would carry out at that time those things that you request.

Mr. Sundquist. Thank you, Dr. Hughes.

Thank you, Mr. Chairman.

Mr. Montgomery. Thank you, Don.

Nancy Johnson.

Mrs. Johnson. Thank you, Mr. Chairman.

I am very interested in the contrast in methodologies between the two studies, because it has always appeared somewhat mysterious to me that there seemed to be such conflicting evidence and conflicting comments that would come to me about the system itself. I think the difference between the long-range view and dealing with people who have had long experience in especially trying to make change accounts for the difference in attitude and conclusions.

I very much appreciate the quality of your work and believe it represents a challenge to all of us who are concerned with the quality of health care to make these changes, because frankly, it affirms a number of impressions that I had long before I even thought about coming to Congress, impressions that I have gained from association with both patients and physicians in the VA system. I really believe that you have helped us to join a discussion, or enjoin a discussion, that is very important to us all.

I want to ask you several brief questions. First, would it be possible for us to see some of the questionnaires that you referred to in their original forms, perhaps with the name of the physician deleted? I would be interested in some of the sort of frank comments that appeared at that level. If they are not included in the body of the report, which I haven't had the opportunity yet to review in detail myself, I certainly would hope we would be able to see those in contrast to some of the conclusions that were drawn from that survey.

Dr. HUGHES. Mrs. Johnson, I certainly would not have any problem with that, as long as you protect the confidentiality of those physicians. You may have the whole notebook of letters so that you may look through them yourself. That is absolutely appropriate, yes, ma'am.

Mrs. JOHNSON. I would be very appreciative of that opportunity.

Mr. MONTGOMERY. Without objection, you can submit these statements and striking the names out. That would be all right.

Mrs. JOHNSON. Do you have any comment on the fact that various surveys have shown a high degree of individual satisfaction, personal satisfaction, among veterans as to their treatment in the VA system?

Dr. HUGHES. Yes, ma'am, I'm thankful for that, and I do not want to negate the excellent medical care that is given to the veterans in many instances. I think that certainly we, as I stated in the report, addressed the issues that are generic in the system that we, as physicians, see from our level.

You know, by that I mean that by which we ourselves, as ones who I would submit know what quality care is and what we desire to give to our patients, that's where we're having difficulties, that we are having a hard time reaching that standard for our patients. It is not to say—and I want to make it very plain in this report—that, in fact, there is quality medical care, and I am very thankful for that.

Mrs. JOHNSON. Would any of you care to enlarge a little bit on the issue of employee union contract provisions that you say work against the achievement of quality by the institutions?

Dr. AMSTUTZ. Well, I would just say the problem that we have, in terms of personnel within the VA at our institution, is such that there is very little incentive to really make the system work and be efficient. There are very few rewards. We have problems of recruiting, as I have alluded to, but then, once they are there, there is very little incentives for the personnel to make the system really run efficiently.

Mrs. **Johnson**. In your experience, do the problems that confront the VA system in this area differ materially from the problems that confront State hospital systems or municipal hospital systems that generally are governed—at least in the Northeast—by similar contract constraints?

Dr. **Amstutz**. I can't speak too much to that because I don't know—we do have problems in our county institutions in Los Angeles, there's no question about it. But I think the problems that we have in the VA system are probably an order of magnitude even more difficult, so that there is a scale there. Perhaps some others may have some comments.

Dr. **Bunch**. One of our attendings who spends a great deal of time at the VA also has had a great deal of experience in Cook County. His report is that the operative turnover times and the quality of the X-rays at the county hospital are significantly better, so that at least on that one person's evidence it would suggest that the problem is greater there.

Mrs. **Johnson**. Thank you, Mr. Chairman.

Mr. **Montgomery**. Thank you, Mrs. Johnson.

You know, I am concerned. Most of these distinguished doctors out here head up orthopedic surgery in university hospitals and are also on the staff at VA medical centers. If the VA's medical program has problems, and these doctors are on the staff of the VA, I would hope they would help us. I know the reason for the report, but it is your responsibility to work with us. Maybe when we get through today we will have some of the answers.

Mr. Hall.

Mr. **Hall**. Thank you, Mr. Chairman.

Dr. Hughes, how many letters were sent out by you to various doctors, or was it sent to all of the doctors?

Dr. **Hughes**. I think, of those members of the orthopedic chairmen that have to do with VA hospitals, is probably greater than 60.

Mr. **Hall**. You sent out about 60 letters?

Dr. **Hughes**. Yes, sir.

Mr. **Hall**. Now, the 23-page report that you have filed, if I counted properly—I may have some overlapping—between 25 and 30 of those 60 doctors replied?

Dr. **Hughes**. That is correct.

Mr. **Hall**. About half of them.

Dr. **Hughes**. Yes, sir.

Mr. **Hall**. Now, did any of the doctors that you wrote reply favorably to those letters that you wrote?

Dr. **Hughes**. Yes, sir. Two institutions, or two physicians, wrote back and said:

> You know, we have our local problems and so forth, but we do not have the generic problems that you're talking about.

Since that time one of the two has called me and said yes, we do have those problems.

Mr. **Hall**. Well, I notice that you've got them designated 008, 006, 7, et cetera, throughout. Did you have any of these doctors to reply, maybe two or three doctors who were talking about the same deficiencies in hospitals?

Dr. **Hughes**. Yes, sir.

Mr. **Hall**. Of course, funding is a problem. That's a problem everywhere. I'm not downplaying it, but I understand that.

I notice in some of the reports, on page 8, a doctor numbered 091 spoke of instrument breakage and use, and due to a shortage of anesthesia and operating room personnel, it is often necessary to cancel elective surgery.

Is that a situation that occurs in nearly all of these hospitals, with reference to elective surgery?

Dr. **Hughes**. I would hesitate to use the term "all" sir, because that speaks of moving toward 100 percent. Might I say it does happen in a significant amount of times simply because the flexibility that we have in the operating room is much more constricted—I think some of the other men can comment on that—than we would have in another setting. In other words, we can plan on maybe doing two cases a day, whereas in another arena we might do three or even four. So sometimes, obviously, where we have what is called an elective case, that can be put off until tomorrow if some trauma comes in, that is of a life or limb threatening nature. Then obviously the gentleman would be bumped.

Mr. **Hall**. In one of your cases that you mention on page 10, you say that all arthroplasties has been temporarily suspended, hip operations, because the Amasco-Hall Reamer Drivers are broken, wornout.

Now, is that a common practice in some of these hospitals, where you have hip surgery, that you have to postpone it because of wornout equipment?

Dr. **Hughes**. It does happen, sir. To say that it's common, I don't want to mislead you. Whether it was common for us as scientists would be greater than 50 percent, I would say.

Mr. **Hall**. Do you ever get out into any of these hospitals that you have received these reports from, personally go into the operating rooms and personally observe any of the matters that have been brought to our attention by this report?

Dr. **Hughes**. I worked in four VA institutions and am aware of what goes on in those institutions. For me to go in and say that I have—I know the individuals who reported, and they are reputable and of concrete character. But I can't say I have been in there and they have showed me this broken——

Mr. **Hall**. Well, have you or any of the gentlemen at the table, been to any of these hospitals and observed personally what these doctors have indicated are deficiencies in this report?

Dr. **Kopta**. Mr. Hall, yes, we have. In fact, the basis of that report comes from our respective institutions in addition to a number of other institutions. So the types of items that are brought out in that report are very firsthand.

Mr. **Hall**. Have you personally, doctor, observed some of the things that are mentioned in this report?

Dr. **Kopta**. Yes, sir, I certainly have.

Mr. **Hall**. For how long in the past have you first observed some of these things?

Dr. **Kopta**. As long as I've been associated with the VA hospital. They have——

Mr. **Hall**. Well, have you ever reported that to any superior?

Dr. KOPTA. Yes, sir.

Mr. HALL [continuing]. In the VA?

Dr. KOPTA. I certainly have.

Mr. HALL. Who?

Dr. KOPTA. We start out with our chief of surgery, and then it goes on up the ladder to the chief of staff, and then to the director of the hospital. Where it goes from there, I don't know.

Mr. HALL. Have you ever observed anything being done to correct those deficiencies?

Dr. KOPTA. Well, yes, sir. As a matter of fact, I did have an experience along that line. The door to our operating room fell off the hinges 6 months ago. We put in two requisitions to get it fixed and nothing happened.

Mr. HALL. Has it been fixed yet?

Dr. KOPTA. When they found out I was coming here to testify, it was fixed.

Mr. HALL. Who did you make that report about this door?

Dr. KOPTA. It was made to the operating room supervisor, who was well aware of it, and then to the chief of surgery and——

Mr. HALL. Is that person here today?

Dr. KOPTA. No, sir.

Mr. HALL. How long did you have to wait for a door to be placed on the operating room?

Dr. KOPTA. Six months.

Mr. HALL. Six months. Well, that's inexcusable.

Going on—and I know my time is up—but on page 12, doctor 131 stated "In the middle of an operation it is necessary to ask for a piece of equipment, multiple instruments, only to be told that they are either lost or unavailable or will be ready in 15 or 20 minutes." That's a deplorable situation, assuming it exists. You state that you know the doctor, 131, who made that report.

I assume he or she is reputable.

Dr. HUGHES. Sir, every single statement in here comes from a reputable person.

Mr. HALL. Is that a situation that has existed in this particular hospital for any long period of time?

Dr. HUGHES. I would have to refer to exactly who 131 is. All I can tell you is that that was a statement that he made in his report, and as a case report that is accurate and true.

Dr. KOPTA. It happens in our hospital at least once a week, that surgery is delayed because of perfunctory malfunction of equipment or supplies are lacking. We had to wait for 20 minutes to get a drain tube, a normal type of thing for hip surgery.

Mr. HALL. Is that common practice in hospitals other than veterans hospitals?

Dr. KOPTA. No, sir.

Mr. HALL. My time is up, Mr. Chairman. I could use another 30 minutes, but I know I can't get it.

Mr. MONTGOMERY. I appreciate the gentlemen's questions. They have all been excellent, and I appreciate the gentleman looking at the report last night.

Mr. Wilson has one question. Mr. Wilson is staff director on the minority side.

Mr. **Wilson**. Dr. Hughes, on page 4 of the report it is stated there is a well-known lack of political courage in the majority of our Nation's politicians. You use this as a basis to predict that the VA will never overcome the faults you find with it.

Would you please elaborate on this statement, and does that have any reference at all to anyone on this committee?

Dr. **Hughes**. I think Dr. Kopta can comment on that. But by the same token, it does take a lot of courage, and I refer you, sir, to a U.S. News & World Report article, or Newsweek, I can't remember which, as pertains to the Grace Commission report. The question was raised, colloquially speaking, does anybody have any guts in Washington. The answer to that is that it does take a lot of courage to address the issues that are involved today. It took courage for us to come. I cannot speak for any member of the group specifically. My assumption—and I think it's an accurate assumption—is that the individuals that are here represented from the Congress this morning will listen carefully, evaluate, and make every due process of thought directed toward satisfying these questions that we have raised.

Mr. **Wilson**. Doctor, have you read the Grace Commission report?

Dr. **Hughes**. Yes, sir, I have.

Mr. **Wilson**. Do you concur with it?

Dr. **Hughes**. I concur with the report in terms of its conclusions, yes, sir. But I am not an economist and a lot of it had to do with the things that had to do with budget and so forth and so on.

Mr. **Wilson**. Did you read just the medical part or the entire report as that report relates to the Veterans' Administration?

Dr. **Hughes**. I read the two units that had to do with the Administration and the other that had to do with the VA hospitals.

Mr. **Wilson**. Mr. Chairman, may I ask just one more question?

In the report, Doctor, there are statements about service organization representatives actually influencing doctors or other medical personnel, or at least that is the inference, by keeping veterans in hospitals beyond the time considered necessary for their treatment so that they can receive increased compensation following a 21-day period of hospitalization.

Could you elaborate on that?

Dr. **Hughes**. Yes, sir. I think it does happen. I cannot speak to the pervasiveness of that consideration, but it certainly does happen in the population. Perhaps one of the others might want to comment on that.

Mr. **Wilson**. Doctor, could you state, if you know, which service organization that was?

Dr. **Hughes**. No, sir, I cannot.

Mr. **Montgomery**. I want to thank the witnesses this morning. You have been most helpful. I would like to point out, though, that you have responsibility in your civilian jobs, as heads of orthopedic surgery departments at the universities and also work with VA medical centers. But we want to point out you do have the responsibility, if we have these problems, to bring them to our attention.

But it would seem to me, if, say, the veterans hospital in Jackson is not doing the job in orthopedics, that that would reflect on the University of Mississippi Medical School because you work at both of them. I would hope that you would be as careful watching the university hospital as you are watching the Veterans' Administration. You have both of those responsibilities.

Dr. **Hughes**. Mr. Chairman, I can assure you that my daytimes are spent working 60 hours of daylight with the University of Mississippi School of Medicine, and my evenings and weekends are spent carrying out some responsibilities to the VA, where I am a consultant. So I can assure you we are here extending our hand to assist you and the Veterans' Administration in absolutely any way we can. That is the motivation for our suggestion to you, that you create a committee where we can dialog in a positive manner in the future.

Mr. **Montgomery**. Thank you very much.

Mr. **Hall**. Mr. Chairman, may I ask one question of these gentlemen?

Mr. **Montgomery**. Yes, sir.

Mr. **Hall**. Dr. Hughes, are all of the numbered men in this 23-page report, are they all board certified?

Dr. **Hughes**. The majority are board certified, that is correct. When I say all, sometimes a resident may bring a report in terms of the actual—he may tell his chief what goes on, and obviously he is in training. But the vast majority, probably 85 to 90 percent of those things that are represented, are absolutely—and Mrs. Johnson can document that when she looks at the letters—are board certified members of the American Academy of Orthopaedic Surgeons who care about the health care for the veterans.

Mr. **Hall**. Thank you.

Mr. **Montgomery**. We would hope, when you submit this information to the committee, you would show whether it is a part-time or full-time position. I think that would help us analyze the information that we're getting.

Dr. **Hughes**. That may take some time, sir, because I would have to rewrite each person to ask, but certainly I will give it a try.

Mr. **Montgomery**. Thank you very much. We appreciate you gentlemen being here this morning.

I would like to call to the witness stand Dr. Earl Brown, who is the Associate Deputy Chief Medical Director of the Veterans' Administration.

I might say to our first witnesses that we hope you would stay, if you have some time. Dr. Rowland, who is a member of this subcommittee, may preside at a later time.

Dr. Brown, you might introduce the other persons at the witness table. You may proceed.

STATEMENT OF D. EARL BROWN, JR., M.D., ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY RALPH IBSON, DEPUTY ASSISTANT GENERAL COUNSEL; ERNEST BURGESS, M.D., MEMBER, SPECIAL MEDICAL ADVISORY GROUP; CARL W. HUGHES, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR PROFESSIONAL SERVICES; AND ROBERT C. LANING, M.D., DIRECTOR OF SURGICAL SERVICE, VA CENTRAL OFFICE

Dr. **Brown**. Thank you, sir.

Mr. Chairman, may I introduce Mr. Ralph Ibson, who is the Deputy Assistant General Counsel, on my far left; to my immediate left is Dr. Ernest Burgess, a member of our Special Medical Advisory Group and clinical professor of orthopedics at the University of Washington in Seattle. He is a consultant at the Seattle VA Medical Center and is nationally known for his work in prosthetics and rehabilitation.

On my immediate right is Dr. Carl Hughes, who is our ACMD for professional services; and to my far right is Dr. Bob Laning, the Director of Surgical Service in the VA Central Office.

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to appear before you to discuss the report on VA orthopedic surgery that was compiled by Dr. James Hughes and Mr. William Spell.

We regret very much the manner in which this report was prepared and released. We in the Department of Medicine and Surgery are subject to review by numerous external organizations, accrediting bodies, veterans' service organizations, and others. The constructive recommendations of these organizations have been of great value in building and maintaining the Department of Medicine and Surgery as a high-quality provider of health care to our Nation's veterans.

We are aware that we have weaknesses in this vast system, and we are constantly striving to correct them. We have excellent clinical and executive management personnel throughout this system who are very capable of addressing the concerns expressed by the anonymous contributors to this report.

Multiple mechanisms exist at every VA medical center to communicate concerns and work through similar problems. I would encourage the contributors of this report to discuss their concerns at the facility level with the Chief of Surgical Service, the Chief of Staff, and the facility director. By open discussion of concerns with local facility clinical and executive management officials, I believe that many of these individuals' complaints can be resolved and that legitimate problems can be addressed constructively.

Mr. Chairman, after we received the report, we prepared a response based on the information at hand. Despite our criticisms of the report, we take most seriously our obligation to render quality patient care and, accordingly, we initiated our own survey to gather data relevant to orthopedic services. We took this action as a first step toward determining if there are significant problems in our orthopedic services. The data we gathered indicates that many of the allegations in the report are unfounded and cite the following examples:

The number of beds assigned and the occupancy rate of orthopedic services is satisfactory; preoperative and postoperative length of stay is satisfactory; 100 percent of our VA medical centers have a flash sterilizer, and resource materials such as cast material and other supplies are available in 99 percent of the VA medical centers after normal working hours; 90 percent of the VA medical centers state that they have methods of discharging patients on weekends and after hours—and there are others. Those are just examples.

Our survey has also identified potential problem situations and areas where we need to work to make improvements in our services. To put some of these problems in context, however, we cannot disassociate them from the existence of a national shortage of orthopedic surgeons and the resultant recruiting problems we face. Nevertheless, we cannot permit this phenomenon to restrain us from attempting to achieve better services where indicated.

Specifically, we are concerned to find data indicating that some of the surgical backlogs reported and waiting times for orthopedic clinic appointments are unacceptable. These data also suggest that in some locations there is a need to increase staffing of orthopedic surgeons, increase the operating room time for orthopedists, and to improve the lagtime in obtaining equipment repairs. There also appears to be a need to reduce 1-day orthopedic admissions for minor procedures and encourage reallocation of funds locally to support special surgical programs such as joint prostheses. We intend to further review these situations and initiate corrective actions as necessary. It is also clear that the productivity of some of our orthopedic programs could be improved, and we intend to pursue this.

It is important to underscore that these problems can and should be addressed at the individual medical centers. When problems of this nature cannot be solved at the local level, the central office can and will be of assistance.

We would point out that many of the concerns expressed in the report are commonplace in the institutional environment where one encounters competing needs and a large variety of specially trained occupations quite naturally focusing on specific professional areas.

At the same time, we see evidence that in some instances existing policy is not being complied with. For example, we have in place requirements for outpatient care of minor conditions, including minor surgical procedures. Our policy does not encourage unnecessary hospitalization or any other aspect of ineffective operations. To the extent that such practices are being followed, they are contrary to both our policy and intent.

Mr. Chairman, on August 11 we provided you with a point-by-point response to the individual allegations contained in the report. I will not repeat these responses but would request that you make that a part of the hearing record.[1]

In summary, much of the report reflects poor communication at the local level and the resulting lack of understanding of or interest in VA health care management. The release of the report and the resulting publicity has created concern among our patients, staffs, and affiliated professional personnel. The report is a disservice to the many dedicated orthopedic services and individuals involved in the VA.

We readily acknowledge that our orthopedic services can be improved. Just like any other health care system, we have to address such problems in the context of competing priorities with the objective of obtaining the most benefit from the resources that we have. We welcome the constructive criticism of any interested group or individual. We would strongly encourage the contributors to this report to become involved with their local medical center and to discuss their concerns within the context of the spirit of their affiliation with the VA and with the objective of improving the quality of services for veterans. We also plan to further review what appears to be problem situations that were identified in our survey and to take corrective actions as necessary.

---

[1] See p. 70.

Mr. Chairman, that concludes my statement. If I may, if you will permit, I would like to call on Dr. Burgess, who would like to at least make an opening comment.

Mr. MONTGOMERY. That will be in order, and, without objection, the materials you would like to submit for the record will be included.

Dr. BROWN. Thank you, sir.

Dr. Burgess.

STATEMENT OF ERNEST BURGESS, M.D.

Dr. BURGESS. Mr. Chairman, I am here for a meeting of the Special Medical Advisory Group which is a congressionally authorized advisory body to the Chief Medical Director and the VA Administrator.

Mr. MONTGOMERY. You might identify yourself again, Doctor.

Dr. BURGESS. I am Dr. Ernest Burgess. I am a long-time orthopedic surgeon. All of these friends of mine that you heard are colleagues, and I am a Professor of orthopedic surgery at the University of Washington School of Medicine. I have been involved in the care of veterans on a consulting basis and probably have operated on 2,000 veterans in the last number of years. I am very interested in the care of these men and women.

Coming back to what I was saying, I am here with the SMAG Committee, Mr. Chairman. We are a congressionally authorized committee of experts, not VA directly related, and we are here at the pleasure of Congress to look over, oversee, and to recommend to Congress certain things about the Veterans' Administration's medical program that are cogent, that are pertinent.

Now, on this committee are two orthopedic surgeons, myself and Dr. Frank Stinchfield. Dr. Stinchfield is recently retired from being the head of the department at Columbia University and he is recent past president of the American College of Surgeons. So orthopedics does have some representation on the SMAG Committee.

I will make a couple of comments briefly, pointing out, from the standpoint of this committee, that we have had an opportunity in the 5 years that I have been on this committee to really look critically and indepth at the VA medical services. I am a lot more intelligent about them now and better advised than I was 5 years ago.

For example, we have a committee on academic affiliation. Now, the VA hospitals in this country are, I would say, the No. 1 seed of resident training for surgical specialities and surgeons in the United States. There are 7,569 residents in medicine and surgery being trained in VA medical centers this day. Of those, 253 are orthopedic surgeons.

Now, why—and I'll make it very brief—why is the VA important to me as a teacher and to the men and women I train in orthopedics? It is the only place in the educational system today, the Federal hospital system, where in a hands-on specialty such as surgery, the instructor, the surgeon, has the opportunity to take residents and give them experience in surgery to a degree that isn't possible for medical-legal reasons even in university hospitals. So the VA is a tremendous reservoir of training. My colleagues recognize that and that's why they are interested in their training programs and their VA affiliation. It is very important. That's one thing.

Now, the second thing is, because the VA medical centers are big and very vital teaching institutions, this affiliation is good for the VA and it is good for the medical school. But one of the things that caused some of the problems—and I sit in the dressing room annoyed by the delay in cases, as I do in private hospitals or other hospitals; I have the same frustrations that these men express. Part of those frustrations, a good part of them, are due to the fact that we are involved in the universities and in the VA in a tremendous amount of teaching.

What is the number one cause for delay in scheduling cases in our VA hospitals? It's anesthesia. Why is it anesthesia? Because the anesthesiologists are training residents and there is just no way out. The anesthesia is well given, but it takes time. It takes time to train a surgeon, to have him do some work with you in a responsible way at the operating table. I can do two total hips at the VA; I can do three in the private hospitals in the same time, primarily because of the teaching involved, among other things.

So I will close by saying that I would hope that this committee would address the important things that have been raised here today, possibly by suggesting that a subcommittee of SMAG be established, a special medical advisory group. We have one on geriatrics, one is being set up on rehabilitation—and Dr. Mooney is going to be part of it—and we have several other committees. These are very vital, active, hard-hitting committees that report to you. I would just enjoy very much having this matter addressed by a subcommittee of the special medical advisory group.

Thank you very much.

Mr. MONTGOMERY. Thank you very much, Doctor. We can certainly tell you're a dedicated person.

Mr. Sundquist.

Mr. SUNDQUIST. Thank you, Mr. Chairman.

Dr. Brown, I assume there will be no actions against anyone who contributed to this report, and if we have any report of that you will deal with it?

Dr. BROWN. Of course. I don't want to know who contributed to the report and I don't know of anyone in the VA who does.

Mr. SUNDQUIST. In your testimony you make the statement that multiple mechanisms exist at every VA medical center to communicate concerns and work through similar problems. "I regret very much these individuals and this organization chose to ignore those mechanisms."

Isn't it a possibility, however, Dr. Brown, that while problems may exist at all the hospitals, that they may not be addressed in the whole scheme of things, and if someone stands back and looks overall, that perhaps there is something to address?

Dr. **Brown**. Yes, sir, there certainly is.

Mr. **Sundquist**. And then when I read in your testimony that the number of beds assigned is satisfactory, the length of stay is satisfactory, this and that is satisfactory, it seems to me that we're going right back to the old way of thinking and saying everything is fine.

Dr. **Brown**. No, sir, that isn't what I implied at all. What I tried to state in my statement is that we tried to sort out those areas where we felt there were major problems and those areas in which there were not problems. In any system this large, and with the tasking that we have, the important task of taking care of veterans from a medical standpoint, we have to use every bit of relevant input that is available in order to understand what's going on in the system, particularly down at the lower working levels. We do that.

I looked at this report in the same manner. We didn't like the report. It was annoying to us. But it is a vehicle of communication, to tell us that there are some problems. This report identified some problems which we have substantiated, in part, with our survey, and we are very concerned about the things that we did come up with.

Mr. **Sundquist**. Thank you, and I would hope you would approach it that way.

It would seem to me that perhaps you should do some surveys of your own periodically, where you might be able to get these results within the VA system. In corporations they do it with employee surveys. They ask "what are people thinking about on particular situations," and if they see a pattern develop that they address it.

Other than the fact that this report was issued in a way that gave some adverse publicity that perhaps did damage the very health care we are trying to improve, I think that these gentlemen, and I assume some ladies, are doing all of us a favor.

This committee does not exist just to defend the VA hospital system. We're after good veteran care. So I appreciate what they have done although I didn't like exactly the way they did it.

Let me ask one question in the brief time I have left. Going back to what I was asking earlier of previous witnesses, in terms of the bed availability and the fact that some of these beds are being filled, so that perhaps the bureaucracy can say "my beds are filled" and that results in, in fact, a delay of orthopedic surgery, would you address that?

Dr. **Brown**. Yes, sir. Certainly in the past it has been advantageous, from a funding standpoint, for the veterans hospitals to keep beds filled. I think we are in the process of solving that with our new resource allocation methodology, which is based, as you know, on the DRG (diagnostic related group). I think this will essentially eliminate those incentives because those people who keep patients in beds an excessive period of time will be penalized rather than receive more funding as a result of it.

I think we are progressing on that. I don't think we have solved it yet, but we will,-beginning in 1985, when we implement the system.

Mr. **Sundquist**. So the statement in here that it is satisfactory is not exactly correct, then, that the number of beds assigned, the occupancy rate of orthopedic service is satisfactory?

Dr. **Brown**. Yes, sir. We felt the occupancy rate and the number of beds was satisfactory. Also, we got a measure of the average length of hospital stay, which we also feel is satisfactory.

Mr. **Sundquist**. The number of beds assigned was what I was referring to.

Dr. **Brown**. Yes, sir. The number of beds assigned we think is satisfactory.

Mr. **Sundquist**. I'm just about out of time, but my question is, essentially, is that 1 minute ago I thought you said we're making some changes in how we assign beds and we are not rewarding those who fill beds.

Dr. **Brown**. No, sir, I was talking about the allocation of funds, not the allocation of beds.

Mr. **Sundquist**. Well, I was asking about the allocation of beds.

Dr. **Brown**. This is an individual medical center challenge to the director to decide the appropriate bed level for orthopedics.

Mr. **Sundquist**. But the allocation of beds, then, is resulting in funds? In other words, the statement was made earlier that by allocating the beds and filling those beds up, then you can justify what you have and perhaps even get more beds, therefore, as I understood the statement, then there are fewer opportunities or delays in orthopedic service.

Dr. **Brown**. I don't know how to answer that, sir.

Mr. **Sundquist**. Well, I'll tell you what I'll do. I will give you something in writing that will fully explain it.

Dr. **Brown**. All right, we will be pleased to respond.

Mr. **Sundquist**. Thank you, Mr. Chairman.

Mr. **Montgomery**. Thank you, Don.

Mrs. Johnson?

Mrs. **Johnson**. Thank you very much.

Dr. Brown, while I agree that the way this report was released to the public was unfortunate and did not serve the best interests either of the VA or of this committee or of the men and women who had put so much time into that report, nonetheless I am keenly disappointed in your response this morning. I am keenly disappointed in the defensive tone and, in spite of all the comments about good communication in which we're interested, I think you are ignoring the substance and the importance of the comments that have been made by very respectable and dedicated people.

I would remind you that when VA testified before this committee on the issue of availability of health care for female veterans, the comments were along a similar line. But the actions of the Veterans' Administration belied those comments and revealed that, indeed, VA did not believe that services were available as they ought to be because it then sent around a circular, an administrative directive, that reaffirmed the department's position and began to put emphasis on actually dealing with the problem.

Now, for you to talk this morning about your surveys in the light of the comments that were made preceding you as to what happened in those surveys, I, for one, have been involved in a lot of Government oversight work, legislative oversight work. I have been specifically involved with the problem of surveys given by administrative leaders of their own personnel and the difference between the results that you would get and the results that someone else would get. And whether or not your surveys came out with different conclusions, I should think nonetheless that you would be very deeply concerned with what some of the surveys that came to this committee did reveal. Not to be aware and acknowledge to us the limits of the methodology of your own survey is, I think, to be defensive and negative and show a unwillingness to really deal in depth with this report.

To comment, to acknowledge that three operations can be done in the private sector, where only two can be done in the VA system because of the teaching responsibilities is, to me, inadequate. I represent a community with a teaching hospital in it. I know that in most cases the VA hospital is one of a number of hospitals that provide a system for medical centers, where interns get training, and I would say that, unless you can verify that teaching has the same retarding effect on the quantity of medical care available to the public in other such teaching institutions, I certainly could not accept that statement as an explanation for some of the kinds of comments that have been brought up here today.

I think the content of this report is not precisely that 100 percent do or do not have sterilizers, but that some of the sterilizers don't work or don't work in a timely fashion. If 6 months can go by before the door on an operating room is rehung, I should think that you would be willing to take extremely seriously the comments of skilled and intelligent and able men, who have clearly from their testimony tried to create change within the system very, very seriously. And while I appreciate the sensitivity with which members on this committee, who worked for many years to provide quality health care, would react to the kind of statement that is in this report, about politicians lacking courage and that kind of thing, nonetheless, as one who has been in Government for a long time, I know that the bureaucracy and elected officials both have a great deal of difficulty responding to the kinds of problems that clearly able people within our system have been trying to deal with on different levels for a number of years.

It is an acknowledged difficulty for anyone who has been involved in this business. Connecticut is involved in this now with bridge inspection difficulties, in terms of the bridge collapses and the lives lost that we have suffered. I say let's get with this; let's not relegate it to a committee that's been in existence. Let's get new people involved; let's get some of the old people involved who have been very dedicated. I know that it's not easy to try to monitor a system as large as ours. You're dedicated, you're working hard. This is true certainly of other people; people on this committee. But I really wanted to make a very clear and strong statement about my disappointment at what I see as the relatively defensive tone of the department in the face of this information.

Let's take it for what it is. Let's try to meet this challenge head on. Let's try to deal with the issue of quality of an enormous, lethargic, overly-structured bureaucracy.

Thank you very much. I don't have any time for questions. But I will——

Dr. BROWN. Mr. Chairman, may I respond?

Mr. MONTGOMERY. Yes, Dr. Brown.

Dr. BROWN. Mrs. Johnson, I apologize if I came across defensively because I did not intend to. We came up in our survey with some things that concerned us very deeply. I think there are things that are happening in our hospitals from the orthopedic surgery standpoint that are of great concern. For example, the average waiting time for orthopedic clinic appointments was shown to be 7 weeks, which I consider to be too long, and we need to do something about that. The average turnaround between operations was 30 minutes, which is too long, and we need to do something about that.

We are taking this report very seriously, and that is what I intended to communicate. I apologize if I did not.

Mrs. JOHNSON. Mr. Chairman?

Mr. MONTGOMERY. Mrs. Johnson.

Mrs. JOHNSON. I think it would have been much more helpful if you had identified that 7-week lag, put that up against the other study as to what was done, saying we have too many rooms and too much unused capacity, and dealt with how you're analyzing some of these problems and what you're planning to do. I hope that in the future we will have more dialog of that nature.

Dr. BROWN. Thank you.

Mr. MONTGOMERY. Thank you, Mrs. Johnson.

Dr. Rowland, who is a member of this committee from Georgia, and he is also a medical doctor.

Dr. ROWLAND. I have no questions, Mr. Chairman.

Mr. MONTGOMERY. Mr. Penny?

Mr. PENNY. Mr. Chairman, I have no questions at this time.

Mr. MONTGOMERY. OK. I want to thank you, Dr. Brown. I hope you will stay around to hear the other witnesses. We find that sometimes our Government witnesses leave and we would prefer they stay to hear what the others say.

Dr. BROWN. I will stay, Mr. Chairman.

Mr. MONTGOMERY. And we want to thank the other witnesses. Doctor, thank you for your remarks.

I believe our other witness, Dr. Rockwood, became ill on a flight into Washington yesterday. We will include his statement in the hearing record, without objection.

Another witness, Dr. Gartland, is also unable to be with us this morning.

[The statement of Dr. Charles Rockwood appears at p. 101.]

Mr. MONTGOMERY. The Chair would like to call the next witness, Dr. Peter Kenmore, who is chairman of orthopedic surgery at the Georgetown University School of Medicine, Washington, D.C.

Dr. Kenmore, you may proceed.

STATEMENT OF PETER I. KENMORE, M.D., PROFESSOR AND CHAIRMAN OF ORTHOPEDIC SURGERY, GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE, WASHINGTON, D.C.

Dr. KENMORE. Mr. Chairman, my name is Peter Kenmore. I graduated from Mamaroneck High School in Mamaroneck, N.Y., in 1941, attended Harvard University and got my M.D. degree from Hahnemann Medical College and Hospital in 1947, and ever since then have been in orthopedic surgery. For 20 years I worked as the chief of orthopedic surgery at the VA hospital here in Washington, D.C. I spent 4 years on active military duty 2 of them overseas as an orthopedic surgeon.

I was a full-time Government employee until just 2 years ago, when I became the chairman of orthopedic surgery at Georgetown.

I have read the report of the Association of Orthopaedic Chairman. On the one hand, the Veterans' Administration hospitals certainly are a very important part of the health care of millions of Americans. On the other hand, there is no doubt in my mind that everything that is in the report is true for at least some of the hospitals, if not most of them.

At the Washington VA Hospital we are blessed with a very good administrator, Mr. Gavazzi, who has been most helpful, and I know from personal experience that not all administrators and chiefs of staff are as helpful as he is. There are serious problems in many of the veterans hospitals and I would like to just mention three.

The most frustrating thing is the unavailability of records. You see patients in the outpatient department and for up to half of them you can't get the medical records, and you can't get the lab results. It is very hard to guess at what happened before in the years of treatment of these veterans.

I would say the second most worrisome thing is the situation in the operating room. Certainly equipment is outdated often. The turnover time, I think a half-hour would be perfectly fine. This is no where near the truth. It is not at all unusual to have an hour-and-a-half turnover time in the VA hospital, and the reason I think is this: There is no provision made for working past the normal working hours because there is no money for that. The personnel know that if they have a turnover time of an hour-and-a-half, the third case is going to be canceled and they don't have to do it. So it is an artificial problem, engaging the turnover time to at least an hour-and-a-half, in many instances, not due to teaching, but just a way of delaying the operation so that one-third of the schedule can be canceled in that room.

Now, for the last 15 months at the VA hospital here we have had the very good fortune to have a wonderful nurse who has been in the VA system for 26 years. She is the acting supervisor of the operating room, a Mrs. Rose Skinner. Just 5 days ago today a permanent supervisor was appointed. She was not appointed as the supervisor because she did not have a degree. A lady who has never spent any time in the operating room was appointed because she had a master's degree. If any one surgeon, or all of the surgeons, had been asked who should get this permanent position, everybody would have said Mrs. Skinner, who in the 20 years at this hospital has been an outstanding employee. Nobody asked any doctor whether this should be the supervisor of the operating room but, instead—you know, she's a very nice lady who has never been in the operating room, but had a master's degree and was chosen to be the supervisor. This just happened last Thursday.

Now, there are many problems, and once you have been in a place for a long time you sort of know how to slide by them and make things work anyway. But if I park my battered old 1975 station wagon on a newly paved parking lot—and it is being paved again and new white lines are being drawn again--and I walk there on North Capitol Street past the beautiful renovation—the front of the hospital was just remodeled. It must have cost many millions of dollars. And I walk through the lobby that is beautifully furnished, it has been recently refurnished, and I thought the last furnishing were real good.

You know, I think how am I going to tell this guy who comes from West Virginia that we are not going to be able to do his total hip because he needs a special procedure, and we have got to get a special head of the femur and socket for him, and it's costing a little more, and we're going to have to wait for the next quarter for financing. We want to know is he going to stay in the hospital or is he going to go home in the meantime. Of course, if he stays in the hospital, he is going to run up a bill of so many hundreds of dollars a day and 4 weeks later this procedure is going to cost a whole lot of money, more money than it really did if you bought it in the store.

Well, I really request that this committee, Congress, in its wisdom, establish a new group of representatives from the central office of the VA and representatives from the chairmen of orthopedic surgery all over the country, to get together with members of this committee and thereby allow the people that are working with the patients some input in how money is spent and what the priorities are and who should get promoted on the basis of merit.

Thank you.

[The statement of Dr. Peter Kenmore appears at p. 91.]

Mr. MONTGOMERY. Thank you very much, Dr. Kenmore, for taking the time this morning to be here.

You mentioned paving the parking lots and money not being spent well, that it probably would be better to put the money into medical care and orthopedic equipment. As I understand it, hip joints are very expensive.

In defense of the VA, a lot of the money is assigned by the Office of Management and Budget, and it comes up here as a line item. The VA really tries and sometimes they are overruled by the OMB or by the administration. My point is, as you say Mr. Gavazzi is a good man——

Dr. KENMORE. Yes, he is good. I think he tries real hard to help us.

Mr. MONTGOMERY. Mrs. Johnson?

Mrs. JOHNSON. I would just comment very briefly that I think your statement, Dr. Kenmore, is eloquent testimony to the fact that good people have been communicating and making an effort to create change and address some of the problems for a long time, and we really do need to find a fresh way to assure that change does occur. That is really what we're all here about. I very much appreciate your frankness, your straightforwardness, and the vividness of the image of the parking lot, the lobby, and the medical care. Thank you.

Mr. MONTGOMERY. Dr. Rowland.

Dr. ROWLAND. No questions.

Mr. MONTGOMERY. Dr. Kenmore, who extended you the invitation to appear before our committee this morning?

Dr. KENMORE. The Central Office Surgery——

Mr. Montgomery. Of the VA

Dr. Kenmore. Of the VA.

Mr. Montgomery. Well, you can certainly say they are fair. They're not going out trying to get witnesses who——

Dr. Kenmore. I might have surprised them with what I said, but I just tried to be honest.

Mr. Montgomery. Well, I want to give them some credit this morning. They have been beat over the head this morning, but you were invited by them to be here. They need a plus anyway, Mrs. Johnson.

Thank you very much, Dr. Kenmore.

Dr. Kenmore. Thank you, Mr. Chairman.

Mr. Montgomery. The last witness this morning—and I appreciate the witnesses cooperating with us the way they have—is Dr. Paul Schafer, the executive director of the National Association of VA Physicians. Dr. Schafer, we know a lot about you. You do a lot of surgery. You have been totally involved with the VA, and we appreciate your dedication.

You may proceed.

STATEMENT OF PAUL W. SCHAFER, M.D., EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF VA PHYSICIANS

Dr. Schafer. Thank you, Mr. Chairman, members of the committee. I very much appreciate this opportunity to present the position of the National Association of VA Physicians in respect to the report.

My name is Paul W. Schafer. I am a physician, a surgeon, and though I speak here today in a strictly unofficial capacity as executive director of NAVAP, it is only fair for you to know that most of my professional career has been in the academic milieu. I am a product of the surgical residency training program at the University of Chicago, where after a brief stint on that faculty I left to become professor and chairman of the Department of Surgery at the University of Kansas School of Medicine in Kansas City.

My preceptor at the University of Chicago was Dallas B. Phemister, and it was my great privilege to have been the last surgeon he trained. Dr. Phemister's accomplishments have few parallels in the history of modern surgery. His laboratory and clinical investigations concerning bone disease and his innovative operative techniques in orthopedic surgery are widely acclaimed. His Monday evening orthopedic conference was attended by colleagues from all over the world and it became my great honor to run these conferences during the last 2 years of my time in Chicago. I am thus not unfamiliar with the clinical field that is the subject of this report.

In Kansas City I became actively involved in the University's affiliation with five hospitals of the VA system. I know first hand what the prospect is from the academic side of affiliation.

I later served as Chief of Thoracic and Cardiovascular Surgery at the Walter Reed Army Medical Center and there trained a generation of the Army's surgeons who served with distinction in Korea and Vietnam. I now continue my service in the Federal-public sector as Chief of Thoracic Surgery at the Veterans' Administration Medical Center here in Washington, D.C. My current academic identification is as professor of surgery at Georgetown University. All that having been said, it should not be necessary to amplify for you that I have no biased tilt away from the academic scene.

I would also like to emphasize that the National Association of VA Physicians is the national professional organization of all salaried physicians employed by the Veterans' Administration, all 11,534 of whom are, by definition, NAVAP members. A majority of the 6,818 full-time physicians are active NAVAP members, meaning they pay their dues.

NAVAP members represent all medical professional disciplines. Many are also members of their national specialty organizations. Active NAVAP membership includes physicians from all levels of clinical and administrative responsibility.

Incidentally, NAVAP first learned of this report as it was made available to us by your committee. We questioned to what extent it was supported by the parent organization of the subcommittee which published it. Of course, that matter has been treated now in some detail. Because of its anonymous anecdotal nature, and the fact that it obviously originated and was promoted from the academic side of affiliation, our first effort was directed toward finding as many objective references as possible.

The NAVAP computer's data base revealed that the Veterans' Administration at June 30 of this year employed 292 orthopedic surgeons, only 59 on a full-time basis. Over half of the other 233 are paid on a less than even half-time basis.

The report identifies VA physicians by numbers, ranging from 001 to 210. These numbers show not a single VA physician response from 18 of the 29 employment deciles, and half of the deciles with responders could boast no more than two in the report. Thus, to be considered significant, the 32 physicians who did respond would have to be identified as well-informed representative individuals. The author of the report was asked to furnish their credentials—no names or facilities to be identified. He declined to do so.

Thus, we do not know whether 008 is a mature, sensitive, and knowledgeable surgeon, who has dedicated himself to a lifetime of serving the needs of sick and injured veterans, or whether he or she is just out of residency training, working for the VA only long enough to study for specialty board examination, who, with successful passage of which, will opt out for the lucrative income of the private sector marketplace. Thus to become one of the minimal part-time attending, consulting or other intermittent surgeons who might rather see the veteran operated upon in their private hospitals instead of inside a Veterans' Administration facility.

The authors insist on anonymity. OK. But how does one evaluate their expertise, the color of their credentials, if you please?

I am a working surgeon and have practiced in both public and private hospitals, academic and otherwise, long enough to recognize the stories which comprise 18 pages of this 27-page report. They bespeak the breakdown of meaningful interpersonal communication and a retreat into complaints rather than forward, problem-solving movement to get a better job done.

This was clearly illustrated when I talked to some of NAVAP's active orthopedic specialists. In talking to them, it was possible to identify the surgeon who had reported budget limitations to only four hip replacements a month. On being chided that surely he had been able to do something about such a ridiculous situation as that, he admitted that with a little better effort they were now doing four cases a week.

I have never worked in an operating suite with nurses and or technicians like those described in this report. It has been my experience that people respond to proper challenge and guidance and literally break their backs and hearts. The unrelenting carping which characterizes this report suggests much immaturity and naivete and almost obscures the valid themes that cry for attention and constructive treatment.

But before we address these important issues, let me make clear NAVAP's absolute rejection of physician 110's observations which the report dignifies by their inclusion at page 23. Recreation services do provide elective experiences which patients do much appreciate, but they also provide consultative and therapeutic activities that greatly enhance the prospect of a veteran patient's recovery.

Second, labor organizations—yes, unions—they are here to stay. Their functions are clearly defined by statute and they are implemented by contract, and in many instances physicians, like other Federal employees, should be so fortunate.

But last, and most importantly, the observation that "the provision of health care to veterans * * * is made increasingly difficult to do by legions of VA service representatives who invade the wards * * *" is nothing less than obscene. Without the expenditure of treasure, energy, and influence by the service organizations, there would not even be a veterans medical program with its 172 medical centers serving the needs of sick and injured veterans.

I am not priviledged to know your name, orthopedic surgeon 110, but I say to you, "for shame." And the same to those responsible for inclusion of these obscenities in the basis for their findings, conclusions, and recommendations.

It would, however, also be a shame for this oversight hearing to miss the great opportunity to address and to become the basis for constructive treatment of two serious threats faced by the veterans medical program. NAVAP's charter requires that we treat these serious matters. NAVAP exists for the purpose of preserving and strengthening the veterans' medical program and to promote recognition that physicians and other health care professionals of the highest caliber are an indispensible part of that program.

By any set of objective standards, the VA health care delivery system affords high quality health care to deserving veterans within the restraints imposed by budgets centrally defined by administrative and legislative authority. Within the next few years new DRG-referenced medicare payments will become the driving force for delivery of health care in the private sector, academic and otherwise. The private sector will then confront the real world. The present strong veterans' medical program has been tempered in the crucible of defined resources. The private sector is yet to be tested. This is no time for carping about the proven success of the one and for pleas to mainstream or otherwise move the care of veterans into a private sector yet to prove it can meet the challenge of delivering quality health care on a tight budget.

This is not to say that the present level of quality in the veterans medical program cannot be improved. It can be and it should be. The rapid advances in medicine involve methods and materials that clearly increase costs and, to the extent possible, these should not be denied to veterans. These apply to nonsurgical care as well as to surgery. They apply to cardiac, thoracic, vascular, neurosurgery, and to others as well as to orthopedic surgery. Physicians obviously want the best for their patients, and to the extent possible they should have it.

I brought along just a few examples of state-of-the-art materials and their cost. This is a human thigh bone, the femur. It is involved in two of the joints which are most often replaced by prostheses. At the top is the hip joint and at the bottom is the knee joint. The hip joint is the more frequent of the two.

I would like to show you here the metal prosthesis that is used to replace the top of this bone. This is the plastic socket which is inserted into the pelvis. The two are articulated together like this to make a hip joint. If someone would take this up to you, Mr. Chairman, I would like for you personally to feel the smoothness with which this joint operates. As you feel it, think of a veteran able now to walk again without pain. But the cost is over $2,000 a joint, and that is by no means the latest development in terms of hip joint prostheses, and I am sure they will cost even more.

This, incidentally, is the prosthesis that is used at the bottom of the bone as part of the knee joint. It is only slightly less expensive than a hip joint. But at four per week, that is $8,000, or nearly a half a million dollars a year for one joint alone.

And that's just for starters. The disposable pump tubing and oxygenator required for a heart operation costs over $3,000, with each replacement valve going for $1,600 each. The weekly material cost alone for a minimal heart surgery program weighs in at $25,000 a week, well over $1 million a year. But it's only money.

In today's high-technology environment, these innovations come so fast that prospective budgeting lags far behind the real need. The VA's hierarchical bureaucracy is poorly structured to respond to the rapidly changing needs of this new order. One cannot but be concerned that proposed revisions in the budget process will be sufficient and on time.

For example, the agency's highly touted MEDIPP process, as the acronym defines, is referenced to the so-called grassroots of the VA medical district. This focuses attention on those grassroots and on the whole bureaucracy and the extent to which direct patient care professionals have an opportunity to apply their awareness and expertise to the most meaningful implementation of the program.

In spite of promises and protestations to the contrary, in the leadership of the agency's 172 medical centers, only five physicians are to be found as facility directors, and so long as physicians serving in such important roles are denied special pay by administrative fiat, that number will not increase. Only 3 physicians are to be found among the agency's 28 district directors, and no physician is a regional director.

Of even more concern is the paucity of physicians to be found in the agency's structured leadership program. In each year since its inception, this program has accepted 60 applicants. In the beginning, 10 of the 60 were physicians, and in 1979 only 9, in 1980 only 6, and this number was reduced to only 3 physicians in both the 1981 and 1982 classes.

It is clear that the valuable insights of the most critical of all the agency's health care providers from the patient interface are not and will not be represented in its bureaucracy unless positive changes are made.

Outside of the VA, one must call on the other relevant agencies and departments of Government to accept their responsibilities if the Nation's contract with its deserving veterans is to be honored. Aging hospitals have to be replaced by modern facilities at a greatly increased pace. Capital expenditures to implement the needs of modern medical technology must be increased. A classical example of this is the X-ray monitoring C-arm mentioned in this report. It is equally useful for vascular and neurosurgery and in other applications. They cost over $100,000 each. And lastly, but more importantly, a sufficiency of qualified personnel must be provided to meet the health care needs of our aging veteran population.

Mr. Chairman, I thank you, on behalf of all those who bind the wounds of war, for the opportunity to express our concerns and to suggest the directions which need, very much need constructive treatment.

Thank you, sir.

[The statement of Dr. Paul Schafer appears at p. 93.]

Mr. MONTGOMERY. Thank you very much, Dr. Schafer. I am sorry more members were not here to hear your full testimony. It was certainly excellent and it will help the subcommittee.

Dr. Schafer, you are the executive director of the National Association of Veterans Administration Physicians, and generally, I assume, your statement has been approved by the executive committee?

Dr. SCHAFER. Yes; at our last monthly national board meeting, this was approved by all the national officers as a formal action of the organization.

Mr. MONTGOMERY. Besides being full time with the Veterans Hospital here in Washington, you are a professor of surgery at Georgetown University?

Dr. SCHAFER. That is my academic title. I discharge those duties at the Veterans' Administration Hospital.

Mr. MONTGOMERY. Dr. Schafer, the report issued by Dr. Hughes, how would you summarize that report?

Dr. SCHAFER. I think it is a cry. I think that is the best word I can use to describe it. I think it is very poorly constructed for presentation, and I think it greatly compromises the serious attention that should be directed toward the issues that are raised.

As I said in my testimony, I think much of what is included in the anecdotes must surely come from a highly-localized, parochial, perhaps immature view of a very, very large nationwide problem, and I have to discount some of that. But as I said in my testimony, the issues that are visible as one looks through the detail of the report, in spite of its anecdotal nature, I think are very serious issues. We are very, very much underfunded to meet the needs that our aging veterans must have.

I mentioned only briefly the problem not just of the prostheses and the materials of other aspects of medical care but the failure to provide adequately the capital assets that are needed to make our medical centers modern and effective, the new operating table that should be there to replace the one that's 10 or 15 years old, at $25,000 a piece.

That C-arm that I just barely mentioned, that is what makes it go. That is what makes for accurate and precise awareness of the critical things that happen during surgery, for example. It certainly speeds up the time that the operation requires and, most importantly, it insures that the veteran gets exactly what is needed.

Mr. **Montgomery**. Dr. Schafer, I am a little concerned in Dr. Hughes' report, and what the other surgeons said here this morning, that the surgery team in the VA is not that loyal, that they are just there to make a living and that's about it. I know what your answer will be, but that was the assumption from Dr. Hughes, or somebody else who was stating that you couldn't get but a certain number of operations.

Dr. **Schafer**. Let me answer your question, Mr. Chairman, with a real life anecdote of my own—I surely am entitled to one—and that was my day yesterday.

I went into the operating room yesterday morning at 8 o'clock, and I came out at 6 p.m. We operated on one patient, and we operated on a medical problem that I have been identified with for 40 years, namely, the problem of a cancer of the gullet, the esophagus, the food tube that comes down through the chest. The lesion was so high that we had to open the abdomen first, mobilize all the parts. It was very difficult because the poor man had had a prior operation on his abdomen and there were all sorts of adhesions.

When we got that all done, we closed the abdomen, we re-positioned, reprepped, redraped, opened up the right chest, mobilized the entire length of the food passage preparatory to moving the stomach up into the chest, resecting the esophagus and the tumor and making a new passageway.

Right at the very last part of this operation, inside the chest, we found a widespread tumor way up in the very top of the thorax. We had to abandon the operation. We worked this whole day, literally, and we accomplished very little. But oh, how we did try—and not just the surgical team, but the nurses and the OR technicians and the anesthesiologists. I can only tell you that not once was anybody in that room doing other than the very best they could do for that patient.

I think the spirit that exists in the veterans' medical centers is just great. I really do believe that. I think wherever people do identify with and care about other people, and try to work together under proper guidance and under proper development of interpersonal attitudes, I think we get jobs done. Sure, we have frustrations. I have them as many times as anyone else who is in this room at this moment.

We do need more money. We do need better capital equipment, and our aging hospitals do need to be replaced faster. We do need the people in a sufficient number and quality, people of all kinds. But oh, it is a marvelous program and we are so fortunate to have it to serve the needs of our veterans. As the NAVAP charter says, we're going to do our damndest to preserve it and strengthen it.

Mr. **Montgomery**. Thank you.

I have only one other question—and you touched on it at the end there—and that is pertaining to money. We have the largest budget we have ever had for veterans and the largest we have ever had for medical care. It was one of the three agencies that had an increase in personnel of 2,000 persons for fiscal year 1984.

I am a little surprised that the county and State hospitals, who are having to cut back on funding all over the country, can have better equipment than we have in the veterans hospitals. How do they get it? I know at the University of Mississippi Hospital in Jackson we have the best X-ray equipment now available in certain types of cases. I saw that equipment. It was so good that I could pick out where the problems were on the different X-rays that they showed me. They can move the X-ray instead of moving the patient.

Dr. **Schafer**. Mr. Chairman, I realize that we fared very well under your leadership in terms of our budget for the current fiscal year, as to personnel and as to dollars. What I am saying is there is still not enough. I realize that in an economy such as we have, where other agencies of Government took cuts while we got an increase, we are appreciative of that. I am merely pointing out that it does take more money than even that which we have.

Now, coming to the comparison of community, county and State hospitals, I'm not competent to judge about that because I have not worked in such institutions for many years, so I am not able to comment. But I can comment about the specific example that you picked up from my report and your experience, namely, the X-ray monitoring equipment. It is my understanding that that is a kind of procurement that is controlled by OMB as they define what kind of moneys are going to be expended. That is the capital asset element of the budget and that has been, I believe, held way, way back in the interest of putting more money into other aspects of the program. But when they do that, then it makes for problems of this sort.

Mr. **Montgomery**. I wish under the jobs bill that is now in effect, the $4.5 billion that the Congress authorized, which both Democrats and Republicans and also this administration supported, could have geared more of that money toward buying equipment. But the idea was to put people back to work and I know that money is now being used at the different veterans hospitals. It looks like some of it could be used in better areas other than building fences around the VA facilities. But I guess the idea was to put people back to work. I really don't have the answer of how we could have used the money better, but it may have been much more sensible to have bought hospital fracture tables.

Dr. Schafer, I would like to yield to Dr. Rowland now.

Dr. **Rowland**. Thank you very much, Mr. Chairman, and thank you, Dr. Schafer, for being here, and all the others who testified earlier. I apologize for not getting here, Mr. Chairman, for the entire hearing.

Dr. Schafer, in listening to you, I believe that you do not believe that there is a lack of initiative or aggressiveness or determination on the part of those people, specifically in the medical personnel area, who are providing medical care in the VA—that's what I'm getting from what you're saying—and that the report may be based on a very parochial outlook of the Veterans' Administration; is that correct?

Dr. **Schafer**. Well, I can't comment about all the hospitals and medical centers——

Dr. **Rowland**. It's your experience I'm talking about.

Dr. **Schafer**. In my experience, there are just so many ways to work together. I have seen so many failures in the working together, both in private and in Government hospitals.

When you really look at it, there are ways to get things done. I think if more energy were applied in that direction, there would be fewer instances of the type that are represented in this report. That is not to say that perhaps there is great validity in some one physician's experience in some one hospital operating room. But in the general sense, I have not found that problem.

Dr. **Rowland**. You don't find in your experience, then, a great deal of disparity between the services provided by the VA and those provided by the private hospital?

Dr. **Schafer**. The private hospitals that I have worked in and the State and Federal hospitals I have worked in I think share much of the same problem and experience.

Now, there is no question that there is a difference, but I don't think it's a monumental difference.

Dr. **Rowland**. With reference to priorities, about where the money should be, and referring back to Dr. Kenmore's testimony, do you have any strong feelings about the inappropriateness of allocation of the money to the various aspects of the VA?

Dr. **Schafer**. Well, of course, Pete Kenmore is an old friend of mine. As a matter of fact, Pete got me this lovely shiny femur that I brought up here. I respect Pete's view and he made a most eloquent presentation.

It is my understanding—and I am certainly no administrator and no financial genius—but I think the moneys that the facility director spent on the parking lot, the white stripes, and renovation of the front and furnishing the lobby, I don't think he has a way of moving that over to buy operating tables or to hire more people in the operating room. Now, I may be wrong, but that's my impression of the way it works.

Dr. **Rowland**. Do you feel there is any significant adversarial relationship between the administrators of VA hospitals and the medical personnel?

Dr. **Schafer**. Well, I think you will have heard in my testimony, and as you read it, I do think there should be more doctors having the opportunity to come up through the administrative side of the bureaucracy. How in the world are we going to get this wisdom, this expertise, filtered into the bureaucracy if at the lowest levels the leadership program, the facility directors, the district directors, regional directors, if we don't have some interested and able physicians coming up through that system?

Now, I have heard the argument that doctors are so scarce, their skill is so special, that we can't waste them in administration. Well, believe me, we had better be putting some of their talents into administration if we are to have the most effective bureaucracy that I think the veterans medical program needs. So I don't want to dodge your question about adversarial relationships between clinical people and administrative people. I would much rather focus my attention toward trying to have the best of both worlds.

Dr. ROWLAND. Am I hearing you saying that administrators would function better if they had a medical background?

Dr. SCHAFER. Well, no, I really didn't say that. I was trying to actually put doctors into the leadership program and let them come up through the system.

NAVAP did a survey a few years ago—and it's in the records of this committee and in the reports associated with the bill that later became Public Law 96-330. We developed the background of all of the facility directors in the system. As you looked down through there, you really began to wonder if some of them perhaps were not being placed in requirements that somewhat exceded their prior training and experience. I think this reached its most ridiculous reference when we found that one facility director's background was that of a mortician.

Dr. ROWLAND. Do you have any thoughts about how the relationships could be improved between the medical personnel and the administration?

Dr. SCHAFER. Well, of course, my thoughts have been directed differently. I have made some general observations and pleaded for constructive treatment.

You see, I envisage NAVAP as a constructive treatment. It is one of many options. The fact is if NAVAP didn't exist it would have to be invented, because what NAVAP really is is a professional organization that allows for individuals to make their problems known and to try some way, somehow, to achieve solutions.

I meet with and talk with members of the staffs of relevant committees of the Congress, with the service organizations, with personnel in OMB, try to keep a foot in the door over at the White House, and I try to maintain the very best relations I can with the VA Administrators, the 10th and 8th floors. I have found Harry Walters and Don Custis to be enormously forthcoming and cooperative.

We are trying to get good things done. I'm not saying there aren't many roads to Rome.

Dr. ROWLAND. My time is up. Thank you, Dr. Schafer.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you very much, Dr. Rowland.

Thank you, Dr. Schafer.

I would like to give Dr. Hughes and the other surgeons 5 minutes, because of our limited time, if they would like to come back to the witness table, to make any comments. Since Dr. Hughes and the others have come a long distance, certainly you're entitled, as you requested, to make any comments based on what you have heard from the other witnesses.

I might point out the parking lot that was mentioned, that is the same thing as putting a fence around the buildings and putting people back to work. That funding, I am sure, did come out of the jobs bill that was passed by the Congress.

Mr. **Fleming**. Mr. Chairman, that is the point I wanted to make, that there has to be a better understanding of the way the budget process works. You cannot take construction money—and the jobs bill was specifically designated for that purpose—and say we should be doing something in orthopedic surgery. It just doesn't work that way, unfortunately. There has to be a better understanding, I think, of the budget process. That may be one of the problems, that the people who responded to this are not aware that you can't use that money for any other purpose than what it was appropriated for. That was the point I wanted to make.

Mr. **Montgomery**. Dr. Evarts?

Dr. **Evarts**. Mr. Chairman, in the interest of time, I would like to request that we be able to submit some written responses to some of the comments that have been made. With your permission, we will do that.

Mr. **Montgomery**. Without objection, we certainly hope you would.[1]

Then we have a number of questions that we would like to ask your panel this morning, and it would be helpful if we could get answers back and put in the record on that.

Dr. **Evarts**. I'm certain you can.

Mr. **Montgomery**. Of course, I am sure a number of people across the country will be reading this report—I certainly hope so.

Dr. **Evarts**. I would like to close only by saying that I think what you have seen has been a very concerned group of physicians who have taken the time at their own expense to come and share with this committee some of our major concerns.

I would answer, without equivocation, the allegation that these are not responsible people by saying they all represent people in positions of major leadership within the field of surgery and orthopedics in this country.

I would state, also, that our thrust is to try and develop a mechanism where orthopedics as a major specialty can interface with your committee and the veterans hospitals to help solve some of these problems.

Mr. **Montgomery**. I certainly accept the testimony from your group, Dr. Evarts, as constructive criticism, and that you are here today to try to improve the treatment in veterans hospitals.

I think it has been an excellent hearing, one of the best that I have been involved in. I am sure some feathers have been ruffled in some cases. It wasn't intentional, but this is what we have to do. I am sure some pluses will come out of these hearings.

The subcommittee now stands adjourned.

[Whereupon, at 10:50 a.m., the subcommittee was adjourned.]

---

[1] Not received at time of publication.

APPENDIX

REPORT OF THE COMMITTEE ON VETERANS' AFFAIRS OF THE ASSOCIATION OF ORTHOPEDIC CHAIRMAN, JULY 1, 1983

The Association of Orthopedic Chairmen is composed of the chairman of the Department of Orthopedics of the medical schools of the United States.

The Committee on Veterans Administration is a subcommittee of the Association of Orthopedic Chairmen. Each Veterans Administration hospital has an association with a medical school and most medical schools have a working relationship with at least one VA hospital. Dr. James Hughes, division of orthopedics, University of Mississippi Medical School, Jackson, Mississippi, is chairman of the Committee on Veterans Administration of the Association of Orthopedic Chairmen.

This report was compiled and prepared by:

Dr. James Hughes, Chairman
Division Orthopedic Surgery
University of Mississippi Medical School
Jackson, Mississippi 39216

William E. Spell
Attorney at Law
Sullivan, Hunt, Spell & Henson
720 North President Street, Suite 240
Jackson, Mississippi 39216

PREFACE

The Veterans Administration is the largest health care provider in the United States.

The VA operates 172 hospitals and 49 independent clinics. The hospitals also contain 15 domiciliaries and 92 nursing home care installations. It employs in excess of 228,000 personnel, including over 12,000 professional medical specialists and over 30,000 nursing personnel.

For many years the VA has provided hospital, surgical or psychiatric services to over 1,000,000 persons annually. More recently, the number of persons treated annually has reached approximately 1,500,000.

Assuming an annual rate of increase and health care cost of twelve percent for the decade, by 1990 the VA will face health care costs of more than 12 billion dollars annually which is about double the budget for FY 82.

The cost of VA health care, in the very near future, may rise so high that the American people are unable or unwilling to provide health care for veterans.

The reluctance of taxpayers to support such a high medical care cost will be intensified if the medical care delivery system is so filled with administrative burdens and inefficiencies that the amount and quality of health care is significantly less than the money could buy if the program were properly administered.

This report consists of the very candid assessment of VA health care procedures, policies and practices and is based upon the daily observations of practicing clinical physicians who practice in the VA hospitals. These observations were made over many months and, in some instances, years.

This report differs from other studies and reports of VA health care services in that the findings, conclusions and recommendations are based upon the private, first-hand information of physicians in the best possible position to know the facts. Also, the observations were made over a long enough period to establish the true and continuous status of VA health care. In addition, no official of the VA approved, influenced or in any way participated in compiling the information, arriving at the conclusions or making recommendations contained in the report.

So that the physician participants, except for the chairman, would be protected from any recriminations and so that each participant would be free to express their findings and recommendations without fear of reprisal or influence for or against the VA, the report has been coded so that the individual physicians will not be identified. The code numbers following each statement identifies each physician and the VA facility involved. The original documents signed by the participants are held in confidence by the chairman in the event there is a need to disclose the identity of any individual or institution and such disclosure will if necessary, be made under circumstances that will protect the physician-participant.

Admittedly, this report reflects the bias of orthopedic surgeons who are concerned about their patients and their particular specialty. It is also significant to note that the manner in which the report was compiled removes the bias that would have been inherent in the report had it been necessary to coordinate the findings, conclusions and recommendations with the VA bureaucracy that the report identifies as the principal deterent to effective and efficient medical care. It should also be understood that participants were asked not to report occurences that were only isolated incidents nor were they asked to enumerate each occasion on which medical care was compromised or made more costly. What the survey sought and received was examples of conduct that established a pattern of the medical care deficiencies.

The fact that there is within the VA system a substantial quantity of quality health care does not excuse an increasing deterioration of medical care which, if not reversed, could jeopardize the entire program. It is also not within the conscience of the participants in this study to excuse any failure to meet the standard of medical care for any person for whose treatment the physicians are responsible, particularly if the patient is one who has faithfully served in the military defense of our nation.

NATIONAL ACADEMY OF SCIENCES REPORT

In June, 1977, the National Academy of Sciences presented the final report of a study conducted by the National Research Council, National Academy of Sciences which was made pursuant to Section 201(c) of Public Law 93-82. The report is entitled, "Health Care for American Veterans".

The participants in the above referenced study were indeed persons of the highest standing in their profession and are certainly competent in their medical or other professional specialty.

Nevertheless, the findings and conclusions of this report made by the Committee on Veterans Affairs of the Association of Orthopedic Chairmen, in some instances, differ sharply from the findings and conclusions made by the Committee of the National Academy of Sciences.

These variances result primarily because of the difference in methodology used in the two studies. The National Academy study used a sample of only eighteen hospitals on a single day to determine the characteristics of the patients and the services they had received. The Orthopedic Chairmen study involved all of the hospitals and drew upon the experience of physicians that ranged from one year or less to several years in the VA system.

The National Academy study dealt more with data collected by survey and the Orthopedic Chairmen study dealt more with specific cases over an extended period of time.

Some of the findings and conclusions of the two studies, while different, are not significantly relevant.

Other differences are so divergent and material that they compel a totally different assessment of the standard of medical care delivered within the VA system and the availability of such care to veterans.

For instance, the National Academy study states "it seems clear that the VA system has more operating rooms and more surgeons for the operating work load than are required". (Page 153) This would imply, if not state outright, that there is no surgery backlog in the VA system. That certainly is not the case. It is true, as pointed out by the Orthopedic Chairmen study, operating rooms are underutilized for various reasons and surgeons perform fewer operations in the VA system than are performed in other hospitals. The reason for that is that administrative budget constraints and other administratively established conditions delay or prevent surgery that should be performed. Hence there is, on many occasions and at several VA installations, unperformed surgery on veterans who need surgery and, as a consequence, for long periods must endure pain and suffering that could be alleviated by improvement in the administration of the hospital system.

The National Academy study stated "in 1975, nearly half the veterans discharged from VA surgical beds had no surgery during their stay. This indicates a need for better screening of applicants in admitting offices." (Page 276) The Orthopedic Chairmen study confirmed that surgical beds are often occupied by patients who are not candidates for surgery or who are discharged without surgery.

This situation does not result from the lack of proper screening but from administratively imposed conditions that place good medical practice secondary to administrative objectives.

The general conclusion of the National Academy study that "patients are generally satisfied with surgical care received in VA hospitals" (page 275) overstates the quality and availability of VA medical care and understates medical deficiencies.

Although the National Academy report points out several undesirable aspects of VA health care and reaches the conclusion that the root cause of the problems stem from unwise administration, the report does not identify in detail the extent to which clinical procedures are adversely affected.

Also, investigators and consultants who compiled the National Academy report were almost without exception detached from the daily operation of the VA health care system while the physicians who provided information for the Orthopedic Chairmen report have experienced daily the frustrations resulting from the conditions on which they report.

WHOLE SYSTEM FAULTY

There seem to be few differences among the various institutions. When one works within this system, it does not take long to discover the significant impediments to patient care imposed by the system. The entire system is so grotesquely inefficient and wasteful that a detailed accounting of specific procedures and incidents would seem to be unproductive and would merely reflect a compilation of the current "frustrations of the week". The bureaucracy which feeds on the system and the political and civil service systems which sustain it are the basic problems with the system. The noble ideals upon which the VA was established have long been forgotten, except when convenient for political rhetoric. Only a truly radical reorganization of the system would provide medical care properly to those individuals for whom the VA system was established. My own opinion is that a true revolution of the VA system will never occur because of the political cost and the well-known lack of political courage in the majority of our politicians. 080

The Veterans Hospital, like many government institutions, is run too much by the clock. Getting the work done, whether it is an operation or other patient care activity, has a very low priority. It often seems that it is more important that everyone get their breaks at the appropriate time and get off at the appropriate time. In our own hospital, we can seldom get more than two major operative cases done in one day, and it sometimes occurs that we can't even do that because of late starts and early ending times in surgery. 067

Apparently, budget decisions about VA hospitals involve inpatient days more than anything else. This is counterproductive in providing efficient care.

Patients who can most effectively be served by outpatient surgery, for example, have to be admitted for a day or longer in order to maintain the financial support of the hospital. There are usually ways around this, but it involves additional cumbersome administrative efforts on the part of the physicians. Streamlining of policies for achieving more real efficiency would allow budgeted dollars to go further. 068

FUNDING METHOD HURTS MEDICAL CARE

Another way in which life is made difficult within the VA system is the method of funding. The VA receives distributed funds which basically take care of day-to-day operations and personal services. In addition, there are a variety of restricted funds which cannot be used for purposes other than which they are allocated. While on the surface this may seem a perfectly logical way of operating, in fact, it restricts the ability of local management to make decisions that are logical and in the best interest of patient care. An example would be recurring and non-recurring maintenance and renovation funds. Monies that are allocated for recurring and non-recurring maintenance and renovation cannot be used to cover expenses in other areas (such as patient care). If they are not used for maintenance and renovation, they are lost. This explains why when the pharmacy runs short on funds and physicians are constantly badgered about their prescribing habits and the need to reduce expenditures, we see parking lots being paved when they don't need to be paved and sidewalks being replaced when they don't need to be replaced. It greatly impairs the credibility of managers when physicians see these things happen, and they occur constantly. The fact is that the maintenance and renovation funds and construction funds, both of which are restricted, are allocated sometimes years in advance, and priorities often change. But the funds still have to be used for the purpose for which they were originally allocated and getting them changed is extremely difficult.

MEDICAL CARE OFTEN DELAYED

Resident (physicians) feel particular frustration in seeing patients and not being able to properly care for them. 001

One of the major problems we run into is the prosthetic and orthotic devices needed for our patients. There are at least four VA hospitals (in this area) and any veteran who needs a prosthetic or orthotic device, whether he is an outpatient or an inpatient, has to go to the largest hospital first for measurements and later on for fitting and it is not uncommon for patients to make several trips for varying adjustments. This obviously prolongs the inpatient care at these hospitals. A recent example was a patient who underwent a resection of the upper two-thirds of the femur for malignant tumor and had to wait at least six weeks before he could be fitted with the orthosis and he had to just sit around the hospital until he got fitted with it. If we have a patient who needs a back brace, he also has to go by ambulance to (that single hospital) for the fabrication of various orthotic devices for the feet. 002

OPERATIONS CANCELLED

Another problem is operating room scheduling in the face of an operating room supervisor who would rather not work and is close to retirement. The solution is to spread the work thin whenever we can, dig in and fight when we must. This is a weekly problem.

Because of low budget allowances over the past year, we have had to cancel a few total joint arthroplasties and reschedule them for other quarters or fiscal years. We have an informal agreement with our supply service and our prosthesis and instrument suppliers in our area to loan these on short notice with the hospital replacing (later buying) those parts used. 005

OPERATING ROOMS LACK OF EQUIPMENT

Our operating room cannot sterilize things rapidly since there is no flash autoclave. This means a twenty-five minute wait for a dropped instrument or for a prosthesis which needs to be sterilized. 005

I do not believe that decisions to operate in acute problems or in chronic problems should be made by administrators who control monies. If this facility limits the number of implants that we can do each year because of money considerations, I may be forced to return to the days of the early kidney transplants and form a committee consisting of a layman, a hospital administrator, the chief of staff, myself and possibly an orthopedic resident and we will sit in judgment in order to prioritize operations for patients in pain. 037

POOR EQUIPMENT HURTS SURGERY QUALITY

Problems experienced in giving high quality surgical care to the orthopedic patient have had several sources. The sources range from incomplete sets of instruments, incompatible instruments and prothesis, plates and screws, inexperienced persons in the instrument preparation area, lost/stolen instruments and insufficient funds for repair and purchase of new instruments. 048

incompatible instruments and pins have presented problems recently. The Knolles and Gouffon pins were from one company, the instruments, in particular the wrench, were from another company and could not be used with the pins. Results were increased anethesia time for the patient and an enormous amount of frustration and anger for the surgeons, operating room staff and supply personnel. 048

OPERATING ROOMS USED INEFFICIENTLY

We currently have an orthopedic surgery waiting list of anywhere from fifty to seventy patients in general orthopedics and double that number in hand. It has been impossible for us to get additional operating room time in order for us to reduce this workload, even though manpowerwise we can fulfill our mission and operate more than we do now. 008

In the operating room, there are no dedicated personnel for particularly difficult specialty procedures. This results in many times having operating room staff who are totally unfamiliar with a particularly difficult surgery routine, which I feel adds to the complication and infection rate. This is especially true of all subspecialties such as eye, neurosurgery, the pacemaker service and orthopedics. This also causes a tremendous problem with instrument breakage and use. Due to a shortage of anesthesia and operating room personnel, it is often necessary to cancel elective surgery routinely in order to get trauma taken care of. It precludes the semihigh emergent case from going to the operating room, i.e. a fractured hip either has to be done at 2:00 in the morning as a "true emergency" or it must wait until Tuesday, the next operating day. If we try and schedule it for 7:00 or 8:00 the following morning, then it is no longer an "emergency". 091

One of the major difficulties is not having enough operating time. This creates a backlog of patients requiring operations. It is not uncommon for a patient to be in the hospital for a week or so waiting for a cancellation or someone not using their operating time. This is a waste of both VA and patient time. There is a backlog of patients requiring operations. Once the schedule has been filled for the quarter, the residents do not feel free to schedule far in advance into the next quarter for the following residents and so the patients are simply appointed back to the clinic; again, a waste of both resident's time, patient's time and VA time. The patients are brought into the hospital two days prior to admission because we have difficulty getting labs back on the chart in time for anesthesia to evaluate. Despite this measure, anesthesia most frequently will see the patient the afternoon before surgery and then decide that various consultations are required. Medicine consultations at this late time are difficult or impossible to obtain, and frequently result in the surgery being entirely cancelled or at least delayed. 101

EMERGENCY ROOM INADEQUATE

The emergency room facilities and the twenty-four hour coverage necessary for a trauma area are lacking in all VA medical centers. In spite of this, there appears to be a policy to admit all veterans regardless of the acute nature of the trauma. The personnel on hand for emergency care are not particularly trained and are found to be mainly moonlighting medical specialists and residents. As a result, an acute trauma problem that exists does not necessarily get the proper life support procedures that are available at an acute trauma hospital which is prepared for such emergencies. Therefore it seems evident that the VA should either (1) upgrade its emergency facilities across the board or (2) change the policy and not admit multiple injured or acute trauma victims. Considerable time delay, as you can imagine, cannot be to the benefit of the patient.

OPERATING EQUIPMENT MAINTENANCE POOR

Equipment is surprisingly extensive and of appropriate quality. Our orthopedic operative array is by no means complete, but it is more than adequate. Maintenance drags woefully behind, considering the quality of equipment we have. Little, if any, regard for the care of the instruments is shown by the staff with only several notable exceptions. A ridiculous method of handling all instruments and equipment in central is a dismal failure. Expensive instruments are broken, improperly packaged and even lost. In addition, while new equipment can be fought for in committee and eventually purchased when a somewhat tight budget will allow, there is no regular allotment for replacement of broken equipment. Currently, we have two broken (worn out) old Amasco-Hall Reamer Drivers which are unreplaced and we wait patiently for possible approval, then available funds to purchase a new Reamer-Driver. Temporarily, we have suspended all total hip arthroplasties as our only source of acetabular reaming are old Smith-Peterson cup reamers. 111

PRE-OPERATIVE WORK-UP UNSATISFACTORY

Presently, orthopedic section has been given a maximum of fifty-two beds including minimal and extended care. Our census now is around sixty-five patients with various patients on non-orthopedic wards. Our quota has been exceeded due in part to the following reasons: (1) Delays in obtaining pre-operative x-rays and the subsequent difficulties in finding x-rays. (2) The admitting of veterans transferred here post-operatively for their rehabilitation. At the present we have approximately 4 or 5 of these patients. (3) Because of the lack of adequate operating time, we have awaiting surgery 14 patients in the hospital, 18 patients on the outside of the hospital, and 5 spinal cord injury patients. 114

SURGERY BACKLOG

It has been increasingly difficult for us to maintain adequate operating time for orthopedic surgery. Personally we have a significant number of patients both within the hospital and outside the hospital waiting elective surgery. Many of these patients have become extremely frustrated regarding this situation. We realize that the number of anesthetists, nurses and aides are well below the quota for employment. We hope that every attempt is being made to remedy this situation as quickly as possible. 118

For the past five years the spinal cord injury service has been working in their surgical cases within the orthopedic priority time which is not an ideal situation. At the present time we have six patients waiting for surgical procedures and it is totally impossible to work through the current orthopedic priority time. Spinal cord injury is a separate service and I think should have its own operating time, although I don't think we need a large amount.

POOR OPERATING EQUIPMENT ENDANGERS PATIENTS

There is also a complaint of poor repair and maintenance of orthopedic operating equipment often making essential tools or components unavailable in the middle of an operative procedure necessitating and reverting to archaic or less than acceptable approaches to the procedures and, in addition, resulting in increased operating time and possibly poor operative results. Most conspicuous is the problem with power equipment which frequently does not function properly, if at all. Another delay is the basic orthopedic operative set-ups which are not put together and sterilized in advance. Most recently lists were submitted for instruments necessary for certain operating procedures and even with a handwritten list of required instruments (which should not be necessary), the instruments are not brought to the operating room sterilized prior to the surgery. Therefore, in the middle of an operation, it is necessary to ask for a piece of equipment, multiple instruments only to be told that they are either lost or unavailable or will be ready in fifteen or twenty minutes. This situation occurs repeatedly on basic set-ups even within the same week on identical procedures in spite of informing scrub and circulating technicians what we wish to be on the sets. All the above has created a frustrating environment for the orthopedic residents and staff physicians and most importantly, the frustrating environment created affects the patient and severely and unnecessarily fosters substandard medical and surgical care. 131

OPERATING SCHEDULING BAD - PATIENTS SUFFER

The formal surgical schedule for orthopedics is not accurate and does not reflect the day-to-day difficulties since (1) we are generally told we simply will not be able to be granted operating room time and therefore we do not schedule cases; (2) we schedule cases that are simply disregarded and never enter into the formal operating room schedule to be cancelled; (3) on normally full operative days we are often told we can do one case instead of the two to four cases we could accomplish under reasonable conditions from 8:00 a.m. until 3:00 p.m. and (4) operating room turnover generally runs from 45 minutes to 1 1/2 hours instead of 20 to 30 minutes, thereby cutting into true operating time and forcing cancellations.

MORE PATIENTS - LESS FUNDS

In a month I am seeing at least sixteen patients needing total joint replacement and the budget only allows for four. 205

X-RAYS, LAB WORK TOO SLOW

We have a constant tussle with the radiology department in obtaining proper view of the x-rays or getting any special procedures done. 003

There is a problem of inefficiency in getting lab EKGs, etc. to the charts before pre-operative patients. The solution is to admit patients two days pre-operatively, which is an uneconomical fix. 004

AGING VETERANS HAVE INCREASED NEEDS

Another problem is the ever increasing age of the veterans. It is not uncommon to find degenerative arthritis of the hips and knees which requires total hip or total knee arthoroplasty and because of lack of funds we cannot have a good inventory and we always have to struggle to get the equipment for these operations. Because of our friendly, various company representatives, we are usually able to get around that problem; but I can see in the future because of ever increasing prices, we might have to cut short the services that we provide to these veterans. 003

ORTHOPEDIC PROBLEMS WILL INCREASE

I have enclosed a table taken from a VA publication listing the fifteen most common diagnoses accounting for service connected disabilities. As you can see, six of the top eight are orthopedic problems. In this hospital, orthopedic residents comprise ten percent of all residents in surgery. Nonetheless, the orthopedic service admitted twenty-three percent of all the admissions to surgery and did seventeen percent of all the operations in the surgery department and saw twenty-two percent of all the patients in clinics. Again, this is a very high work load which will only be increasing as the ages of the patients increase. 038

RED TAPE DEPRIVES TREATMENT, RAISES COST

We were told by the inspector general's office recently to reduce our outpatient visits by 20,000 visits per year. In order to do this, elegibility for the nonservice connected outpatient has been limited. After referral from the life support unit, the NSC veteran can only be treated for thirty days. Not infrequently, it takes three weeks just to get an appointment to the orthopedic clinic so there is only a short period of eligibility left. A diagnosis may be made and treatment initiated, but cannot be followed through to completion because of the veteran's limited eligibility. 045

We are encouraged to keep a high inpatient census in order to insure that central office funding (based on ADC) will not be cut. We have been told that the outpatient clinics are to evaluate people and prevent them from requiring inpatient care. Yet we are told that we must limit the number of patients seen in the outpatient clinics. The only way an NCS veteran can be treated for something as minor as Trochanteric Bursitis is to admit him to the hospital so that he will be eligible for longer follow-up care. This, in my opinion, is not good medical practice. The services should be rewarded for a low bed census and a fast turnover rate rather than have somebody sit around needlessly to keep beds full and increase hospital census. 045

ADMISSION POLICY COSTLY

We finally got a waiver on the rule that all patients must be admitted, and we can follow them as if they were admitted. Normally, a fractured clavicle, a finger fracture, and more minor fractures do not require hospitalization. Theoretically, we cannot treat them unless the patient is admitted. 046

EQUIPMENT REQUESTS WAIT WHILE PATIENTS SUFFER

The patient was taken to the operating room for exploration of his left or axillary nerve. He gave a history of shoulder dislocation with an axillary neuropraxia and essentially complete paralysis at deltoid muscle. We explored the axillary nerve looking for a lesion that could be repaired. In surgery, we found out the axillary nerve was badly damaged in the quadrangular space and we did perform a sural nerve graft. We encountered considerable difficulty during this case because the operating room has insufficient microsurgical instruments to perform these complicated procedures. Our surgery team had the technical expertise and unfortunately struggled, in my opinion, unnecessarily, because we have not been able to obtain the instruments to do these procedures. I have been attempting for three years to encourage the operating room to obtain the equipment that would be necessary for us to accomplish these delicate procedures. Unfortunately, these requests were put in a file and never acted upon. 136

BAD EQUIPMENT - SLOW REPAIRS

Over a period of almost two years, repeated efforts were made to improve functioning of the image intensifying apparatus in the operating room. On many occasions technical servicing was performed but no improvement in the quality of imaging was obtainable. Matters finally came to a head when malfunctioning of the image intensifier, once again, necessitated abandoning a procedure on an elderly patient with a hip fracture. Recommendation was made to the surgeon that no further procedure requiring use of the image intensifier be performed in the hospital until a satisfactory imaging apparatus became available. However, once again, attempts were made to repair the old apparatus to the extent that the previously mentioned patient was placed on the next operating list. On the morning of surgery, however, it was clear that the image intensifier was not functioning. It was necessary to transfer the patient to another hospital for treatment of the fracture. Again, requests were made that no hip fracture patients be accepted into the hospital and that an urgent replacement of the image intensifier be sought. The equipment was over ten years old. After memos were exchanged for several weeks while many other patients were transferred to other hospitals for surgical treatment requiring the use of an image intensifier. The dollar cost to the VA for treatment of these patients was very signifcant. Following the crisis situation arrived at with failure of the image intensifier, a new modern and efficient replacement unit was finally purchased. 210

SUPPLIES SHORT

It also appears that there is no viable system for central supply to inventory their shelf stock and the stock kept in the operating room. We are constantly running out of even the most basic items. Members of the nursing staff in the operating room try to stay on top of the situation, but it continues to be a problem. When orders are finally initiated in the central supply area (sometimes after the stock has been completely depleted) the paperwork frequently sits on a desk in another area of supply service for days, even weeks, before orders are actually placed. At the present time we are completely out of screws and plates for our many fragment sets. The Richard compression set has no leg screws. We do not have all sizes of Steinman pins, no isolation drapes and no completed sets. Two arthroscopes have been lost and many instruments cannot be located or are damaged so badly as to be unusable. 044

DRUG USE RESTRICTED

In order to save pharmaceutical monies the last fiscal quarter, a policy was initiated that nonsteroidal anti-inflammatory drugs (with the exception of aspirin) could be prescribed only with an attending physician's signature. This was designed to cut down costs, particularly the use of Mortrin throughout the hospital for both inpatients and outpatients. It seems very demeaning that a fifth year resident is unable to prescribe drugs for patients being treated by the orthopedic section. This is inconvenient to the residents, the patients and the attending physicians. There should be some other way of cost containment. 045

ADMISSION POLICY COSTLY

Patients must be admitted two working days prior to surgery to allow bloodwork, EKG, CXR to be done. This applies to any elective surgery done with general or spinal anethesia. This increased length of stay is considerable, especially the Thursday elective admission. Patients cannot readily be discharged on weekends or government holidays unless they were admitted the night before. Prescriptions cannot be filled, nor can patients get their belongings so they can leave. Again, inpatient days are increased. Radiographs taken during non-standard hours are difficult to find and their quality such that repeat films are often required. Portable x-rays for femoral or hip fractures are generally poor and need repeating two or three times to be adequate AP and lateral view. 072

SUPPLY SYSTEM PREVENTS BEST TREATMENT

The length of time it requires to get things done within the VA system is very frustrating. In August 1982, I requested supplies so that our residents could treat fractures after hours and on weekends, since the prosthetic area was not open. They arrived in December 1982. In August 1982, we requested some Delta Lite fiberglass cast for use on people with chronic draining wounds so that whirlpool treatment could be done. In January 1983, we still have no fiberglass casting material. My secretary has supplied three separate justifications to supply service. 045

ADMINISTRATIVE RESTRICTIONS VS. MEDICAL CARE

The following items are having the greatest affect on orthopedic service at this hospital:

(1) Limitation of total joint replacement cases to four per month and only to be scheduled on Thursday.

(2) Case cancellation by anesthesia if the case cannot be completed by 3:00 p.m.

(3) The VA regulation for preventing brace needs for outpatients or repair of old braces, necessitating hospital admissions for patients needing braces. 076

We have no facility for outpatient surgery, even for minimal surgical procedures that could be done in local anesthesia and are done in other hospitals in the emergency rooms. At our institution, the case is set to be brought to the operating room and the patients have to have a complete work-up, which includes chest x-rays and EKG as well as the laboratory work. 078

RED TAPE EXPENSIVE, HINDERS MEDICAL SERVICES

Many times because of red tape a patient that could be discharged to an extended care facility or to a nursing home is kept days or weeks at the hospital. Usually at the end of the calendar quarter we run out of money and frequently patients have to be discharged from the hospital and surgery rescheduled because we cannot buy the necessary implants. On several occasions in the past, we have had to postpone or cancel elective surgery because there was no money to pay people for the potential overtime. The scrub technicians break in and out of surgery at a certain time, because according to union regulations they have to have their lunch breaks taken at a designated time. On a few rare occasions the technicians would make "a personal sacrifice" by continuing to help in surgery at a surgeon's request. 079

SYSTEM ENCOURAGES LONG, COSTLY, UNNECESSARY HOSPITALIZATION

The VA hospital systems director, I believe, is to provide health care to veterans - to treat the illnesses and return them to a well state or as close to it as possible. This is made increasingly difficult to do by legions of VA service representatives who wander the wards advising patients to "stay in for twenty-one days, then you will collect 100% disability." It is no small wonder we have to resort to "open threats" to send our patients home from the hospital that provides free bingo for cash prizes, movies, entertainment, tickets to sporting events, cut-rate watches, radios, toiletries, clothing and cigarettes and a full-time Diversion Therapy Department where they make gun cases, wallets and every other imaginable item for their own use at no cost. If we are to run increasingly busy "real hospital services" these negative incentives must stop. Somehow, it escapes me how constructing a model of the Battleship Iowa will help an injured patient more than valid vocational rehabilitation to help him return to the work force. 110

EARTHQUAKE PROOFING VS. PAIN AND SUFFERING

Physician space is another severe problem. While the facility is being upgraded and "earthquake proofed", no attempt has been made to provide adequate orthopedic facilities. The emergency care area is totally unequipped to do any orthopedic work and the "orthopedic ward cast room" is an unused portion of the building, partially equipped, not lockable and also used as an office. 111

ALLOCATION OF PHYSCIAN TIME IMPRACTICAL

A faculty member working at the VA hospital under the prescribed system of "1 8s" and under a strict time accounting system is a financial liability to his non-VA department, at least in the specialty of orthopedic surgery. With the increasing emphasis on private patients as a means of securing faculty support and support of medical schools in this country, a faculty member in orthopedic surgery with an assigned "4 8s" time at the VA cannot afford to spend the actual number of required hours in service and still be expected to generate sufficient funds for his full-time support. 083

PHYSICIAN COMMUNICATION POOR

The hospital mail system is terribly inefficient, often requiring several days for a consult (from within the hospital) to reach the resident physician (also within the hospital). An immediate verbal consult would speed things up, but this apparently has not worked out. 102

NURSE SHORTAGE

Our own orthopedic and rehab ward is constantly understaffed. As many as forty patients are cared for by one registered nurse and two or three aids for evenings and nights. Staffing problems continue to become worse, not better. Even in critical areas such as intensive care and the spinal cord injury units, nurses often work double shifts and even then, some shifts are understaffed. At issue is more than simple financial benefits, as the VA is basically competitive in salary and fringe benefits with the private sector. The VA is, however, straddled with a top-heavy nursing administrative staff. Many of the senior people are ex-military and not up to current trends. Not competent administrators. In addition, no effort is made to send key personnel to educational meetings or build any esprit de corps. 109

FINDINGS AND CONCLUSIONS

1. Veterans, many in pain and with service connected illnesses, are routinely denied treatment for long periods for lack of medical funds while non-medical and much less essential expenditures continue. Lawn sprinklers, earthquake proofing and similar items often are priority over artificial hips, surgical instruments and prescription drugs.

2. Accomplishment of medical procedures, particularly those related to surgery, are made less effective and sometimes are severely compromised by the imposition of employment contract provisions forced on the VA by labor organizations or voluntarily adopted by VA management.

3. The risk of surgery to patients is often signifcantly increased because surgical instruments malfunction, are lost, lack essential components or are poorly maintained.

4. The length of the VA patient's hospital stay and the circumstances under which medical treatment is delivered is quite frequently determined by administrative and budget requirements rather than by standards of good medical practice. Compliance with VA administrative and budgetary requirements often violate the standards of good medical practice and result in higher costs and inferior medical care.

5. The standards of good medical practice are so grossly abandoned in some VA hospitals that young, consciencious physicians and other health care professions are becoming so frustrated that they prefer to work elsewhere. As the competent, dedicated physicians and health care professionals leave the VA system, they are replaced by persons of less dedication and competence and the deterioration of health care is accelerated.

6. The operation of the VA hospital system is dominated by administrators whose bureaucratic philosophy and procedures conflict so sharply with the efficient, effective delivery of medical care that veterans, in many instances, receive substandard medical care, administratively delayed care or, on occasions, no care at all. Some of these administrators are physicians who have deserted the basic and essential concepts of clinical medical practice and have become defenders and advocates of the bureaucratic system that has diminished greatly and, in some cases, totally abandoned good clinical standards.

RECOMMENDATIONS

1. The entire Veterans Administration medical care system should be redesigned and restructured so that the clinical care of VA patients is medically efficient, cost effective and consistent with high standards of medical care.

2. The Administrative bureaucracy of the VA system should not be allowed to prevent or impair the clinical capability and medical standards of health care.

Veterans
Administration

AUG 11 1983

In Reply Refer To: (11)

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on
Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in reply to your letter forwarding the copy of Dr. James L. Hughes' report of The Association of Orthopedic Chairmen and the newspaper article on the subject.

The Department of Medicine and Surgery was unaware of this report or that it was under preparation. It is our understanding that Dr. Hughes, representing the Committee on Veterans Administration, canvassed other chairmen of orthopedics seeking problems in the VA. The report supposedly represents the input he received.

We are aware that we have weaknesses in this vast system and strive constantly to correct them. This report, however, consists of a series of disconnected, anonymous anecdotes which, because of anonymity, does not allow refutation. As such, it is a real disservice to our dedicated VA orthopedists and chairmen of orthopedics, as well as the VA and this country as a whole.

It is obvious from many of the complaints that the responsible physician does not understand the legally mandated requirements for operation of the Department of Medicine and Surgery. This report could have been obviated and most of the complaints settled, or at least understood, by communication at local VA medical center level.

We have contacted a number of our medical centers, orthopedic services, some chairmen of orthopedics, and other interested orthopedists and have prepared an item-by-item response to the report. A copy of the response is enclosed.

We plan to continue to study the allegations and hope to have additional information available for your scheduled hearing.

Thank you for your inquiry and for alerting us to this report.

Sincerely,

DONALD L. CUSTIS, M.D.
Chief Medical Director

Enclosure

REPLY TO THE ASSOCIATION OF ORTHOPEDIC CHAIRMEN REPORT

PREFACE

The three page preface tries to establish credibility of the report based upon the anonymous input from orthopedic surgeons working within the VA. The unsolicited, anecdotal information consists of hearsay and is not collected in any standard study, design or randomized format. Conclusions drawn from such a study have questionable validity. The author states that the report reflected a bias of orthopedic surgeons. While it criticizes the largest health care system in the free world, it was reluctantly admitted that there was a substantial quantity of quality health care.

THE NATIONAL ACADEMY OF SCIENCES REPORT (NAS)

Comments here relate to certain sections of the 309 page NAS document and do not reference the VA response of more than 500 pages. It is true that some of the smaller VA medical centers have too many operating rooms. At the same time, some larger, busier VA Medical Centers (VAMC) have inadequate operating room space. Inadequate staffing of Surgical Intensive Care Units (SICU) also limits the number of major procedures that can be performed. If funding were unlimited and no personnel ceiling existed, extra shifts in both the surgical suite and the SICUs could be established in busy hospitals.

A VA Central Office (VACO) survey in 1978 indicated that 64% of patients admitted to the surgical service were operated upon. The other 36% were admitted for chemotherapy, radiation therapy, for observation for a surgical condition, for workup, or were terminal. Of the patients not undergoing surgery, only 11.4% had a nonsurgical condition.

WHOLE SYSTEM FAULTY

The bulk of the report consists of coded, anecdotal opinions reportedly expressed by orthopedic surgeons knowledgeable of the VA health care system. If the system is so grotesquely inefficient and wasteful as accused in the report, it infers that the multiple systems watching it, including Veterans Service Organizations, the Congress, the White House, the Joint Commission for Accreditation of Hospitals (JCAH), and the various medical organizations have missed the inefficiencies of the VA. Why do the surgeons remain with the VA?

Budget decisions are made on the present clinical workload data. A new system, expected to be in place by FY-85, is being developed to identify budget requirements which will equate more with workload data from each medical center. Outpatient (OP) surgery has been mandated by VACO. Obstacles to this program are being identified and corrected. Costs for OP surgery are greater than for the usual OP visit.

FUNDING CARE OFTEN DELAYED

Funding accounts for construction, renovation and building maintenance are appropriated by law and funds cannot be shifted. Spending here often relates to JCAH requirements for privacy, fire and safety. The criticism that funds are being spent for parking lots when needed for drugs, demonstrates a lack of understanding by physicians making these statements. Pharmacy costs are escalating by millions each year and efforts are made at cost control with physician cooperation while still giving the patient the highest quality of care.

MEDICAL CARE OFTEN DELAYED

The reference to resident physicians' frustrations and ability to give proper patient care is ambiguous and undocumented. Frustration is a common complaint of housestaff and is not restricted to orthopedic surgery or to the Veterans Administration.

It is cost effective to establish centers for prosthetic/orthotic services with properly trained personnel. It does require some patients to travel to the center but better quality devices are assured in this manner and resources do not allow these services at every VAMC. The same considerations apply to smaller, rural private hospitals.

OPERATION CANCELLED

The derogatory remark about operating room nurse supervisors is out of place and undocumented. It is true that the cancellation rate of operations in some medical centers is too high. This results from a whole array of causes including overscheduling and delays in return of x-ray, laboratory and consultation reports. In a few instances, insufficient staffing may be a factor. Computerized reporting systems will correct this to a considerable degree.

Medical Center Directors must prioritize their funds. This has resulted in delay of purchase and stocking of $1,100 - $2,200 artificial joint prosthese at some centers. VAMCs, by law, do not enjoy the privilege accorded private hospitals of maintaining a supply of a wide variety of joint prostheses furnished by manufacturers or supply houses on consignment for use as needed.

OPERATING ROOMS LACK EQUIPMENT

In the preface, the author stated that incidents reported here were not isolated but examples that established a pattern of deficiencies. If the VA has any medical center capable of orthopedics surgery that does not have a flash autoclave, then one would have to question the judgement of the orthopedist who would operate under those conditions.

POOR EQUIPMENT HURTS SURGERY QUALITY

Funding for equipment, replacement and repair are local responsibilities. The state of the art on joint prostheses is constantly changing. It is difficult and expensive to update orthopedic equipment. At Jackson VAMC, where the author of this report is a consultant, the value of the orthopedic equipment is $103,800. The VAMCs and the Medical School Hospitals regularly lend instruments back and forth, assisting each other. The VA cannot pass on the costs of special instruments to the consumer as is done in the private sector.

OPERATING ROOMS USED INEFFICIENTLY

It is the responsibility of the VA Chief of Surgery to allocate specialty surgery operating time in accordance with patient demand and high quality care. Emergency, urgent, and lifesaving surgery take priority. Each specialty surgeon feels his specialty is the most important. Emergencies are always disruptive to an operating schedule. Dedicated personnel for specific types of surgery is possible only in VAMCs with many operating rooms, sufficient staffing, and a large enough workload to warrant it.

Preoperative, outpatient screening and workup for elective cases is a VACO goal and a requirement for the field in the interest of reducing the preoperative stay and costs. This is not always possible because of the distance some patients live from the center. As more ambulatory care is established in the VA, this goal will become more of a reality.

EMERGENCY ROOM INADEQUATE

The Department of Medicine and Surgery (DM&S) has done an extensive study on its emergency rooms. Trauma admissions to VAMCs are limited. All VAMCs have a physician on call or in the admissions area to see emergency admissions. The VA does not support category I emergency rooms which require around the clock staffing with on-site specialists which would allow posting of an emergency room sign on the street. This would invite all comers, including non-veterans. Care of trauma is a national problem and more trauma centers are being established. Since most VAMCs are affiliated with a medical school with an active emergency room, this is a service that most VAMCs share.

OPERATING EQUIPMENT MAINTENANCE POOR

Earlier in his report, the author complained of inadequate equipment. Now he states it is more than adequate but complains of poor maintenance. No doubt maintenance varies from center to center. As with all other requirements, maintenance and preventive maintenance may fall behind depending on priorities based on judgement and priorities of divergent groups and the allocation of funds within the limited budget.

PREOPERATIVE WORKUP UNSATISFACTORY

There are adequate beds for orthopedics throughout the VA. There is always room to expand as indicated. Delays in obtaining x-ray film and limited operating time have been discussed. A conscientious orthopedist will manage to obtain the necessary x-rays for his patient's surgery. An important part of orthopedics is rehabilitation. Rehabilitation is a priority of the CMD, especially with respect to our aging population.

SURGERY BACKLOG

Surgical backlogs do occur in different specialties from time to time. As they do occur, a concentrated effort is made to vary schedules to take care of the patient as particular problems may require, on a case by case basis. Spinal cord injury as a separate service should have its own designated operating time for elective surgery.

POOR OPERATING EQUIPMENT ENDANGERS PATIENTS

Complaints such as these should be resolved locally by presentation to management officials through the Chief of Surgery. At the same time, it is expected that the orthopedic surgeon, or his resident, coordinate with the Operating Room (OR) nurse to be certain the special equipment anticipated is available; otherwise, the case should not be scheduled.

OPERATING SCHEDULING BAD - PATIENTS SUFFER

This has been addressed previously. It is known that OR turnover times vary through the VA; however the turnover time at Jackson VAMC is reported as approximately 30 minutes between cases.

MORE PATIENTS - LESS FUNDS

Funding shortfalls are known to exist for some surgical services, especially where expensive devices are implanted. Surgery for the aging veteran is increasing, including joint arthroplasties, lens implants, vascular and cardiac surgery, etc.

X-RAYS, LAB WORK TOO SLOW

This was discussed earlier.

AGING VETERANS HAVE INCREASED NEEDS

This is one of the CMDs priorities. The VA is well aware of the needs of the aging veteran and is planning accordingly. This planning will include new technology.

ORTHOPEDIC PROBLEMS WILL INCREASE

We know orthopedic problems will increase with the aging veteran population. Incidents noted here represent only one hospital. Throughout the VA, orthopedic inpatients make up 9% of the surgical patients, comprise 9% of the surgical procedures, and make up 8.4% of the outpatients.

RED TAPE DEPRIVES TREATMENT - RAISES COSTS

Unfortunately, limited resources force management decisions within the frame of the law, especially where funding is on a fiscal year basis without benefit of carry-forward as can be done in the private sector.

ADMISSIONS POLICY COSTLY

It is VACO policy that patients be evaluated in an outpatient status to the maximum extent possible and have their preoperative workup performed as an outpatient. Outpatient treatment by law is restricted to service connected veterans and eligible veterans in the "obviate the need" category.

EQUIPMENT REQUESTS WAIT WHILE PATIENTS SUFFER

One has to question the judgement of a surgeon who begins a complex case without assuring himself that he has adequate equipment. Further, these are problems which must be worked out with local management.

BAD EQUIPMENT - SLOW REPAIRS

Fortunately, the equipment mentioned here has been replaced but equipment failure may occur anytime. If equipment repeatedly fails, one should look to the capability and performance of the user.

SUPPLIES SHORT

This has been discussed previously as a local problem and one the surgeon himself should pursue to assure himself of the equipment he desires.

DRUG USE RESTRICTED

This subject referred to previously as an escalating cost item. Non-steroidal anti-inflammatory drug costs are escalating faster than any other drug groups. Management must make necessary decisions to control costs and seek physician cooperation to do so. These drugs are often prescribed when other effective but less expensive drugs work equally well.

ADMISSION POLICY COSTLY

It is DM&S policy that patients have preoperative studies completed on an OP basis where possible. As for weekend and holiday discharge, it is considered cost effective to keep the few patients in rather than have an administrative staff on duty to care for the discharges. With more thoughtful discharge planning by the doctors, patients should be released on Fridays.

SUPPLY SYSTEM PREVENTS BEST TREATMENT

No comment.

ADMINISTRATIVE RESTRICTIONS vs MEDICAL CARE

Addressed previously except for anesthesiologists. This is one of the critical specialties which is obtained to a high degree by expensive contracting for services.

RED TAPE EXPENSIVE, HINDERS MEDICAL SERVICES

Much of this was addressed previously. The references to union rules indicate the lack of understanding on the part of these orthopedic surgeons that 70% of VA employees are unionized versus 20% in the health care industry in general.

SYSTEM ENCOURAGES LONG COSTLY UNNECESSARY HOSPITALIZATION

The VA does not support the service organization representatives encouraging patients to remain in the hospital just to collect their disability payments. However such payments are entitlements by law and serve as a negative incentive for the patient to leave the hospital early. This problem has long been recognized. It is not likely that Congress will vote to discontinue it. [illegible]

EARTHQUAKE PROOFING vs PAIN AND SUFFERING

It appears that the pain and suffering is that of the physicians. Any mature physician should realize the importance of seismic construction and understand and accept the temporary inconveniences in the interest of ultimate safety improvements, for their own welfare as well as that of patients and other staff.

ALLOCATION OF PHYSICIAN TIME IMPRACTICAL

The amount of time contracted to spend in the VA is the individual orthopedist's decision and it is expected he will be honorable and honest enough to spend that time at the VAMC. If the income for the part-time orthopedic surgeon is such that he cannot afford to spend the actual number of hours obligated, then he should leave or work the time for which he is paid.

PHYSICIAN COMMUNICATION POOR

That is strictly a local problem.

NURSE SHORTAGE

Nurse shortage has been a national problem. Congress and the VA have taken numerous steps to improve the nursing shortage. The problem has greatly improved and continues to improve. This statement is another unjustified and derogatory comment and shows a lack of knowledge of the writer of the VA nursing service and its recent advances.

FINDINGS AND CONCLUSIONS

1. The complaint and accusation that many service-connected veterans in pain are routinely denied treatment for lack of funds is unsubstantiated by any evidence. The suggestion that funds should be transferred from one account to another shows the complaintant's ignorance of the budget process and the illegality of transferring such funds.

2. This complaint about union rules is vague and the authors make no suggestions for a resolution. At the same time, they do not seem to recognize the validity of the union's claims to certain work conditions.

3. Occasionally surgical instruments do malfunction. The accusation relates to instrument malfunction or lack of components. Legally, the surgeon is responsible for the patient's surgical care which includes insuring that he has adequate instruments functioning properly with which to operate.

4. The VA is funded by Congress with limited spending authority. There is no validation of inferior medical care or violation of standards of good practice as a result of VA administrative budgetary requirements.

5. The turnover rate of personnel implied is not validated by our own data. With the turnover that exists, there is continuous orientation and instruction of personnel. We find we are able to attract more competent, and hopefully more dedicated, physicians than in recent years. Those who leave are often of the scarce specialty category, such as orthopedics and anesthesia, who leave in order to make more money.

6. This criticism of "administrators" is a personal opinion and may be valid in some of our facilities. It underlines the need for a strong, clinically oriented Chief of Staff who can inspire and lead their chiefs of services.

SUMMARY

This report purportedly represents the Association of Orthopedic Chairmen. Of a number of the Chairmen contacted, none wish to be associated with the report. Some have offered to help refute the report or participate in a panel before Congress. The American Academy of Orthopedics has offered to furnish names of orthopedists for a panel to forestall a confrontation on this issue. The report was prepared by Dr. James Hughes, Chairman of the Committee on Veterans Administration of the Association of Orthopedic Chairmen. The information was collected by questionnaire. The bulk of the report is made up of a series of 38 anonymous, repetitious, disconnected, anecdotal testimonials from unknown individuals, supported by coded referecnes. Many of the selected quotations are ambiguous, rambling, critical and sarcastic, resulting in an immature presentation. The report further revealed the naivete, or ignorance, of some of those submitting statements as to some of the legally mandated requirements for the operation of DM&S.

This report apparantly was completed and copies sent to the media and Congressional Committees before being reviewed by other Chairmen of Orthopedics. Some are quite disturbed by this action.

Much of it also reflects poor communication at local level, presumably because the orthopedic surgeons who are critical are unwilling to sit down with the Chief of Surgery, Chief of Staff, or Director to discuss supply or equipment problems. Often a five minute telephone call or brief personal visit will do more good than 30 memoranda which can lost of misplaced.

Admittedly, there are periods when funds are scarce for expensive programs such as cardiac surgery and prosthetic implants. When brought to the proper attention of the Medical District Director, Region or VACO, relief usually is managed. Backlogs do occur in certain specialties. When properly reported, action also is taken to relieve the situation.

There are 32 full time, 147 part time and 6 intermittent orthopedists employed by the VA. There are 79 VA orthopedic training programs with 253 orthopedic residents. Approximately 9% of all surgical inpatients are orthopedic and orthopedic outpatients equal 8.4%. Orthopedic surgeons perform 9% of the surgery in the VA.

At Jackson VAMC where the author of the report serves as a consultant, orthopedics has 14% of the surgical beds, does 10% of the OR procedures and spends 30% of the surgical budget. The center has an orthopedic staff of 2 1/8 FTEE and 2 residents with orthopedic equipment valued at $103,800. There are 24 patients awaiting artificial joint prostheses. There are osteoarthritic patients who have been followed and are operated on at the rate of 3 to 4 per week. These are not life endangering conditions.

One gets the impression that the author has made this report a personal thing, that it is a national protest against the system. It appears that the author would like a public hearing. It is also suspect that this report might be used as a medium to raise the issue of orthopedics as a separate service within the VA rather than a section under the Surgical Service.

The report makes one wonder if some of the contributors may be somewhat temperamental "prima donas." It is surprising that individuals who feel the VA is so poorly equipped would condescend to see patients, much less operate on them in our ORs, considered to be so inadequate.

AOC
Association of Orthopaedic Chairmen

Statement of C. McCollister Evarts, M.D.,
President of Association of Orthopaedic Charimen

C. McCollister Evarts, M.D.
President, 1982-83
601 Elmwood Avenue
Rochester, New York 14642
(716) 275-5168

Harlan Amstutz, M.D.
President-Elect, 1982-83
Univ. of California Medical Center
Los Angeles, California 90024
(213) 747-7457

Wilton H. Bunch, M.D.
Secretary-Treasurer, 1982-83
2160 South First Avenue
Maywood, Illinois 60153
(312) 531-3280

Denise Frank
Executive Secretary

EXECUTIVE COMMITTEE

James S. Miles, M.D.
Past President, 1981-82

Donald Kettelkamp, M.D.
Past President, 1980-81

Robert D'Ambrosia, M.D.
Program Chairman

Vert Mooney, M.D.
Member at Large

Joseph Kopta, M.D.
Member at Large

Mr. Chairman, Members of the Subcommittee,

I appreciate the opportunity to attend and participate in the hearing on the report prepared by Dr. James Hughes in regards the V.A.'s health care procedures, policies and practices.

The Association of Orthopaedic Chairmen (AOC) feels a responsibility to clarify the record about the report. Although Dr. Hughes is Chairman of the Subcommittee on Veteran's Affairs of the AOC and has long been interested in veteran's affairs, this report was not reviewed and approved by the Executive Committee of the AOC prior to it's release. However, Drs. Amstutz, Bunch, Kopta and Mooney, all members of the Executive Committee, are present today in support of the report.

In studying it's contents there are issues common to many types of hospitals including V.A. hospitals involving difficulties with budgets, supplies and administration - all of which ultimately impact on patient care. It was obvious from the report, however anecdotal, that frustrations were seriously felt by the providers of orthopaedic services due in part to a current breakdown of communication in some selected situations.

In the past, the AOC has worked with the Medical Staff in the Central Office of the VA, and looks forward to working with them to improve communications.

It is important that the problems facing the providers of orthopaedic care continue to be reviewed and discussed with the ultimate goal of better care for the musculoskeletal patient within the veterans' population.

Again, we appreciate the opportunity to testify and would be happy to answer any questions.

6. 7.

We are quick to say that when all VA facilities operated at the high level and standard of some of those represented here today, we also would give our endorsement to the system.

Our report acknowledged that many veterans received good medical care.

The report stated:

> "The fact that there is within the VA system a substantial quantity of quality health care does not excuse an increasing deterioration of medical care which, if not reversed could jeopardize the entire program. It is also not within the conscience of the participants within this study to excuse any failure to meet the standards of medical care for any person for whose treatment the physicians are responsible, particularly if the patient is one who has faithfully served in the military defense of our nation.

Our study was deliberately designed not to praise what is good about the VA health care system, but to determine the practices and conditions that are unacceptable and to discover how that which is unacceptable could be improved and made more cost effective. It seems to us that this purpose should be consistent with the charter and responsibility of your committee, the Congress and the Veterans Administration.

We come before you, Mr. Chairman, submitting our report along with a request that we would like for you to consider. We suggest that you encourage the establishment of a working committee consisting of the medical director of the Veterans Administration and appointees of his selection, members of your committee or designees of your choice and members of the Association of Orthopaedic Chairmen to meet quarterly for an exchange of views regarding VA medical care. From this committee, recommendations could be made that would benefit all those affected by VA medical care, particulrly the veteran patient.

We would be pleased to answer any questions that you may have.

STATEMENT OF
D. EARL BROWN, JR., M.D.
ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR
VETERANS ADMINISTRATION
BEFORE THE
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

September 27, 1983

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to appear before you to discuss the report on VA orthopedic surgery that was compiled by Dr. James Hughes, the Chairman of the Division of Orthopedic Surgery of the University of Mississippi Medical School, and Mr. William E. Spell, an attorney from Jackson, Mississippi.

Mr. Chairman, we very much regret the manner in which this report was prepared and released. We in the Department of Medicine and Surgery are subject to review by numerous external organizations, accrediting bodies, veterans' service organizations, and others. The constructive recommendations of these organizations have been of great value in building and maintaining the Department of Medicine and Surgery as a high-quality provider of health care to our nation's veterans. We are aware that we have weaknesses in this vast system and we are constantly striving to correct them. We have excellent clinical and executive management personnel throughout this system who are very capable of addressing the concern expressed by the anonymous contributors to this report. Multiple mechanisms exist at every VA medical center to communicate concerns and work through similar problems. I regret very much that these individuals and this organization chose to ignore those mechanisms. I would encourage the contributors to this report to discuss their concerns at the facility level with the Chief of Surgical Service, the Chief of Staff, and the facility Director. By open discussion of these concerns with local facility clinical and executive management officials, I believe that many of these individuals' complaints can be resolved and that legitimate problem situations that do exist can be constructively addressed.

Mr. Chairman, after we received the report, we prepared a response based on information on hand. Despite our criticisms of the report, we take most seriously our obligation to render quality patient care, and, accordingly, we initiated our own survey to gather data relevant to orthopedic services. We took this action as a first step toward determining if there are significant problems in our orthopedic services. The data indicates that many of the allegations in the report are unfounded, i.e.:

- The number of beds assigned and the occupancy rate of orthopedic services is satisfactory.

- Pre- and post-operative length of stay is satisfactory.

- 100% of VAMCs have a flash sterilizer, resource materials such as cast material, and other supplies are available in 99% of VAMCs after normal work hours.

- Operating room personnel do break in and out of surgery, but not without replacements.

- Consultation services and anesthesia services are considered satisfactory.

- 90% of VAMCs state that they have methods of discharging patients on weekends and after hours.

- Most orthopedic services attempt to perform pre-surgical diagnostic tests before admission and most VAMCs have outpatient surgery capabilities.

Our survey also has identified some potential problem situations and areas where we need to seek improvement of our services. To put some of these problems in context, however, we cannot disassociate them altogether from the existence of a national shortage of orthopedic surgeons and the resultant recruiting problems we face. Nevertheless, we cannot permit this phenomenon to restrain us from attempting to achieve better services where indicated. Specifically, we are concerned to find data indicating, for example, that some of the surgical backlogs reported and waiting times for orthopedic clinic appointments are unacceptable. These data also suggest that in some locations, there is a need to increase staffing of orthopedic surgeons, increase the operating room time for orthopedics, and improve the lagtime in obtaining equipment repairs. There also appears to be a need to reduce the waiting time for outpatient visits, reduce one-day orthopedic admissions for minor procedures and encourage reallocation of funds locally to support special surgical programs such as joint prostheses. We intend to further review these situations and initiate corrective actions as necessary. It is also clear that the productivity of some of our orthopedic programs could be improved, and we intend to pursue this.

It is important to underscore that these problems can and should be addressed at the individual medical center. When problems of this nature become unmanageable at the local level, Central Office can and will provide assistance.

We would point out that many of the concerns expressed in the report are commonplace in the institutional environment where one encounters competing needs and interests to be served and a large variety of specially-trained occupations quite naturally focusing on specific professional areas. At the same time, we see evidence that in some instances existing Agency policy is not being complied with. For example, we have in place requirements for outpatient care of minor conditions including minor surgical procedures. Our policy does not encourage unnecessary hospitalization or any other aspect of ineffective operations. To the extent that such practices are being followed, they are contrary to both our policy and intent.

Mr. Chairman, on August 11, 1983, we provided you with a point-by-point response to the individual allegations contained in the report. I will not repeat those responses but would request that you make that response a part of the hearing record.

In summary, much of the report reflects poor communication at the local level and the resulting lack of understanding of or interest in VA health care management. The release of the report and the resulting publicity has created concern among our patients, staffs and affiliated professional personnel. The report is a disservice to the many dedicated orthopedic services and individuals involved in the VA. Mr. Chairman, we readily acknowledge that our orthopedic services could be improved. Just like any other health care system, we have to address such problems in the context of competing priorities with the objective of obtaining the most benefit from the resources that we have. We welcome the constructive criticism of any interested group or individual. We would strongly encourage the contributors to this report to become involved with their local medical center and to discuss their concerns within the context of the spirit of their affiliation with the VA and with the objective of improving the quality of services for veterans. We also plan to further review what appear to be problem situations that were identified in our survey and take corrective actions as necessary.

Mr. Chairman, that concludes my statement. I or any of my colleagues will be glad to respond to any questions that you or members of the committee may have.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CONGRESSMAN HILLIS

Question: 1. Please explain why certain funds used at VA hospitals are not interchangeable and why construction funds for instance may not be used for patient care.

Answer: Each appropriation account for the Veterans Administration (i.e., Medical Care, Construction, Major Projects) has specific appropriation language (contained in the annual Appropriations Act) which legally defines and limits the uses for which funds in the individual accounts may be expended. The language in the Appropriations Act regarding the construction account limits expenditures to construction and alteration of VA facilities. Thus, such funds may not be used for any other purpose. In addition, VA is precluded by statute from transferring funds between appropriation accounts. 31 U.S.C., Section 1532.

CONGRESSMAN HILLIS

Question: 2. In your opinion, are patients often admitted as inpatients to VA hospitals for minor surgery that could and should be performed on an outpatient basis?

Answer: While VACO policy dictates that minor surgery be done in outpatient, ambulatory care settings, we still have individual cases admitted that could and should be performed on an outpatient basis. In certain circumstances, the surgeon may consider inpatient surgery safer, overall better quality of care, or simply more convenient. Also, distances traveled, or the home environment of the veteran dictates that some minor surgery that should otherwise be performed on an outpatient basis be performed in the hospital. We are continuing to emphasize the need to perform surgery on an outpatient basis and will continue to monitor our surgical programs for compliance with our policy.

CONGRESSMAN HILLIS

Question: 3. The Hughes report indicates that VA paves hospital parking lots and sidewalks that don't need paving. Would you please comment on VA's methoos of determining what construction or repair projects are needed?

Answer: Each medical center has an engineering staff charged with the responsibility for maintaining the physical facilities. This includes maintenance and repair to all structures, grounds, roads and sidewalks, and equipment. The Chief Engineer and his staff develop a five-year plan for the medical center's maintenance and improvement needs, and on a year-to-year basis evaluate the need for the project based on various engineering standards applicable to the project and their experience in maintenance of facilities.

The projects are developed, estimated, and along with written justification, presented to the medical center director for his approval and submission through appropriate channels for further approval and funding.

CONGRESSMAN HILLIS

Question: 4. As compared to the private sector, or to state, county or city hospitals, how would you rate VA hospitals in terms of quality of care.

Answer: All of the Veterans Administration medical centers including psychiatric, long-term care and ambulatory care facilities are fully accredited by the Joint Commission on Accreditation of Hospitals (JCAH). The majority of our facilities are involved in both health care education and research.

It is our opinion that VA hospitals give as good or better quality of care as compared to the private sector, state, county or city hospitals.

CONGRESSMAN HILLIS

Question: 5. You and your associates--including Dr. Custis--are obligated to evaluate reports on VA hospitals from a number of sources. These reports are sometimes critical of VA's operations. They come from the Joint Committee on Accreditation of Hospitals, from the National Academy of Sciences, from veterans organizations and from others. How would you rate the Hughes report as compared to the other reports which you receive?

Answer: We in the Department of Medicine and Surgery are, indeed, subject to review by a number of external sources. With few exceptions these recommendations, while critical, have been of great value in building and maintaining the Department of Medicine and Surgery as a high-quality provider of health care to our nation's veterans. We are aware that we have weaknesses in this vast system and strive constantly to correct them.

The Hughes report is not comparable to other evaluations. It is a very subjective compilation of a series of disconnected, anonymous anecdotes, which because of anonymity, do not allow a refutation.

CONGRESSMAN HILLIS

Question: 6. Dr. Peter Kenmore testified that merit principles were not followed in the appointment of a supervisory nurse at the VA Medical Center in Washington, DC. Please furnish the Committee information about this appointment.

Answer: Dr. Kenmore's assertion that merit principles were not applied in the appointment of a supervisory nurse at the VAMC, Washingotn, DC, is in error.

The individual in question is a staff nurse who was serving in a acting supervisory capacity pending the recruitment of the supervisory position. At no time did she actually apply for the position. Should she have applied for the job, she might or might not have been rated as a highly-qualified candidate. However, it is pointed out that the educational requirement of the job exceeded those presented by the staff nurse and this alone could have reduced her chances for selection.

In any case, the contention by Dr. Kenmore that merit principles were not applied is at best a moot point and does not capture the facts in this situation.

GEORGETOWN UNIVERSITY HOSPITAL
3800 RESERVOIR ROAD, N.W.
WASHINGTON, D.C. 20007
(202) 625-7613

DEPARTMENT OF SURGERY
DIVISION OF ORTHOPAEDICS

TESTIMONY OF PETER I. KENMORE, M.D. ON SPETEMBER 27, 1983

My name is Peter I. Kenmore, M.D. I graduated from Mamaronek High School in Mamaronek, New York, in 1941, attended Harvard University, and got my M.D. degree from Hahnemann Medical College and Hospital in 1947. Since then I have spent my life in Orthopaedic Surgery. I trained in various hospitals, but primarily the Hospital for Joint Diseases in New York City for five years, and later had a Fellowship at Johns Hopkins University for two years, studying bone diseases. I spent a total of four years in the United States Army, two of them as an Orthopaedic Surgeon overseas. I was in the private practice of medicine for a period of four years, and then decided on an academic career. I have been the Chief of Orthopaedic Surgery at the Washington Veterans Administration Hospital for more than twenty years, all but the last two years as a full-time Veterans Administration employee. Since December 1981, I have been Professor and Chairman of Orthopaedic Surgery at Georgetown University.

I have read the report prepared for the Association of Orthopaedic Chairmen. On the one hand, the Veterans Administration hospitals fulfill a very important need in the health care of millions of Americans, on the other hand I am convinced that every problem mentioned in this report is true for some of the Veterans Administration hospitals. The Washington Veterans Administration Hospital is blessed witha most efficient and dedicated Director, Mr. A. A. Gavazzi, and I know from personal experience with other Hospital Directors and Chiefs of Staff that he is unusual and unusually excellent. There are some serious problems in all of these Veterans Administraion Hospitals, and I would like to mention only a few. Probably the most frustrating problem is the unavailability of the medical charts and the results of laboratory work of the outpatients in the Clinic. Long turn-over time between operations is common, and I know the situation borders on the ridiculous in some of the most perstigious hospitals, associated with the most prestigious medical schools in the country. While a turn-over time--that is, time between the end of an operation and the beginning of the next in the same operating room--of fifteen minutes between operations would be considered good, a one-and-a-half hour turn-over time is not unusual in the Veterans Administration Hospital. I firmly believe that this is often done so that the third operation of the day will have to be cancelled because there will be no time for it during the normal working hours. The equipment in the operating room in not of good quality in many cases. Replacement is hard to come by, and yet surgical equipment needs to be replaced sometimes. The operating room at the Washington Veterans Administration Hospital has run superbly well for the past fifteen months because Mrs. Rose Skinner has been acting supervisor. She has been a nurse in the Veterans Administration system for twenty-six years. She was not given the position of permanent supervisor. Only five days ago a nurse with a masters degree was made supervisor even though she has had almost no operating room experience. If any or all surgeons had had any input into the appointment of the operating room supervisor, Mrs. Skinner would have gotten the job.

In spite of the fact that I came to know the system in my twenty years, and in spite of the cooperative attitude of the administration at the Washington Veterans Administration Hospital, there are problems. When I park my battered 1975 station wagon in the parking lot, beautifully paved and being re-paved, at my hospital at 7:25 in the morning and pass the tremendous renovation of the front of the hospital, which obviously costs many millions of dollars, and walk into the beautifully refurnished lobby that looked very good to me before the refurnishing, I wonder how to tell my patient that he will have to wait several weeks for the new hip prosthesis to be bought and ask him whether he would want to stay in the hospital in view of the far distance that he had to come from West Virginia to have this operation. I do not believe a recapitulation of isolated or not-isolated problems would serve any purpose here.

I urgently request that a dialogue be established between the Central Office and the Clinician who takes care of the veteran, and that Congress in its wisdom make some arrangement whereby some funds could be allocated for medical equipment and medical care rather than for the very expensive renovation or re-building programs, and that promotion be on the basis of merit only.

Respectfully submitted,

Pen. Kenmore, MD.

Peter I. Kenmore, M.D.

NAVAP
NATIONAL ASSOCIATION OF VA PHYSICIANS
6400 Goldsboro Road, Suite 202 Bethesda, MD 20817 (301) 229-9630

TESTIMONY OF

PAUL W. SCHAFER, M.D.

EXECUTIVE DIRECTOR

NATIONAL ASSOCIATION OF

VETERANS ADMINISTRATION

PHYSICIANS (NAVAP)

at the

OVERSIGHT HEARING

COMMITTEE ON VETERANS AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 27, 1983

Mr. Chairman, Members of the Committee, I appreciate this opportunity to present the position of the National Association of VA Physicians in respect to the Report which occasioned this Oversight Hearing.

My name is Paul W. Schafer. I am a physician, a surgeon and though I speak here today in a strictly unofficial capacity as Executive Director of the National Association of VA Physicians (NAVAP), it is only fair for you to know that most of my professional career has been in the academic milieu. I am a product of the surgical residency program of the University of Chicago where after a brief stint on that faculty I left to become Professor and Chairman of the Department of Surgery at the University of Kansas School of Medicine in Kansas City.

My preceptor at the University of Chicago was Dallas B. Phemister and it was my great privilege to have been the last surgeon he trained. Dr. Phemister's accomplishments have few parallels in the history of modern surgery. His laboratory and clinical investigations concerning bone disease and his innovative operative techniques in orthopedic surgery are widely acclaimed. His Monday evening orthopedic conference was attended by colleagues from all over the world and it became my great honor to run these conferences during the last two years of my time in Chicago. I am thus not unfamiliar with the clinical field that is the subject of the Report at hand.

In Kansas City I became actively involved in the University's affiliation with five hospitals of the VA System; namely, in Leavenworth, Wichita Excelsior Springs, Topeka, and Kansas City. I know first hand what the prospect is from the academic side of affiliation.

I later served as Chief of Thoracic and Cardiovascular Surgery at the Walter Reed Army Medical Center and there trained a generation of the Army's surgeons who served with distinction in Korea and Vietnam. I now continue my service in the federal public sector as Chief of Thoracic Surgery at the Veterans Administration Medical Center here in Washington, D.C. My current academic identification is as Professor of Surgery at Georgetown University. All that having been said, it should not be necessary to amplify for you that I have no biased tilt away from the academic scene.

I would also like to emphasize that the National Association of VA Physicians is the national professional organization of all salaried physicians employed by the Veterans Administration, all 11,534 of whom are by definition NAVAP members. A majority of the 6,818 full-time physicians are active members, as are increasing numbers of the 4,421 physicians who are employed part-time. Some of the 295 intermittent, attending, and consultant physicians participate actively.

NAVAP members represent all medical professional disciplines; the major bed services with their respective specialties and subspecialties, as well as all of the supporting services and their specialties. Many are also members of their national specialty organizations. Active NAVAP members come from all 172 VA Medical Centers and Hospitals and their satellite Health Care Delivery Facilities; also from free-standing clinics, domiciliaries, and related activities. They are found in big cities and in isolated places, in school-affiliated institutions and those that are not, in places small and large, anywhere that sick and injured veterans need care in the Nation's largest Health Care Delivery System. The active NAVAP membership includes physicians from all levels of clinical and administrative responsibility.

Incidentally NAVAP first learned of this Report as it was made available to us by your Committee. We also question to what extent it is supported by the parent organization of the Subcommittee which published it. Because of its anonymous anecdotal nature and the fact that it obviously originated and was promoted from the academic side of affiliation, our first effort was directed toward finding as many objective references as possible. The NAVAP computer's data base revealed that the Veterans Administration at June 30, 1983 employed 292 orthopedic surgeons, only 59 on a full-time basis. Over half of the other 233 are paid on a less than halftime basis. The Report identifies VA physicians by numbers ranging from 001 to 210. These numbers show not a single VA physician response from 18 of the 29 employment deciles and half of the deciles with responders could boast no more than two. Thus to be considered significant, the 32 physicians who did respond would have to be identified as well-informed representative individuals. The author of the Report was asked to furnish their credentials - no names or facilities to be identified. He declined to do so.

Thus we do not know whether 008 is a mature, sensitive, and knowledgeable surgeon who has dedicated himself to a lifetime of serving the needs of sick and injured veterans. Or whether he or she is just out of residency training working for the VA only long enough to study for specialty board examination who, with successful passage of which, will opt out for the lucrative income of the private sector marketplace. Thus to become one of the minimal part-time, attending, consulting or other intermittent surgeons who might rather see the veteran operated upon in their private hospitals for a $2 000 or 3,000 fee instead of inside the Veterans Medical Program's facilities.

The authors insist on anonymity....O.K. But how does one evaluate their expertise....the color of their credentials, if you please?

I am a working surgeon and have practiced in both public and private hospitals, academic and otherwise, long enough to recognize the stories which comprise 18 pages of this 27-page Report. They bespeak the breakdown of meaningful interpersonal communication and a retreat into complaints rather than forward problem solving movement to do a better job. This was clearly illustrated when I talked to some of NAVAP's active orthopedic specialists. In talking to them it was possible to identify the surgeon who had reported budget limitations to only 4 hip replacements a month. On being chided that surely he had beer able to do something about such a ridiculous situation he admitted that with a little better effort they were now doing 4 cases a week. I have never worked in an operating suite with nurses and OR technicians like those described in this Report. It has been my experience that people respond to proper challenge and guidance and literally break their backs and hearts to please. The unrelenting carping which characterizes this Report suggests much immaturity and naivete and almost obscures its valid themes that cry for attention and constructive treatment.

But before we address these important issues let me make clear NAVAP's absolute rejection of physician 110's observations which the Report dignifies by their inclusion at page 23. Recreation Services do provide elective experiences which patients do much appreciate, but they also provide consultative and therapeutic activities that greatly enhance the prospect of a veteran patient's recovery. Secondly, labor organizations - yes, unions - are here to stay, their functions clearly defined by statute and implemented by contract, and physicians like other federal employees should be so fortunate. But lastly, and most importantly, the observation that "the provision of health care to veterans...is made increasingly difficult to do by legions of VA service representatives who invade the wards..." is nothing less than obscene. Without the expenditure of treasure, energy and influence by the service organizations there would not even be a Veterans Medical Program with its 172 Medical Centers serving the needs of sick and injured veterans. I am not privileged to know your name, orthopedic surgeon #110 but I say to you, "For Shame!" And the same to those responsible for inclusion of these obscenities in the basis for their findings, conclusions, and recommendations. Again I say. "For Shame!"

It would however also be a shame for this Oversight Hearing to miss the opportunity to address and to become the basis for constructive treatment of two serious threats faced by the Veterans Medical Program. NAVAP's Charter requires that we treat these serious matters. NAVAP exists for the purpose of preserving and strengthening the Veterans Medical Program and to promote recognition that physicians and other health care professionals of the highest caliber are an indispensible part of that program.

By any set of objective standards the VA Health Care Delivery System affords high quality health care to deserving veterans within the restraints imposed by budgets centrally defined by administrative and legislative authority. Within the next few years new DRG-referenced Medicare payments will become the driving force for delivery of health care in the private sector, academic and otherwise. The private sector will then confront the real world. The present strong Veterans Medical Program has been tempered in the crucible of defined resources. The private sector is yet to be tested. This is no time for carping about the proven success of the one and for pleas to mainstream or otherwise move the care of veterans into a private sector yet to prove it can meet the challenge of delivering quality health care on a tight budget.

This is not to say that the present level of quality in the Veterans Medical Program cannot be improved. It can be and should be. The rapid advances in medicine involve methods and materials that clearly increase costs and to the extent possible these should not be denied to veterans. These apply to non-surgical care as well as to surgery. They apply to cardiac, thoracic. vascular, neurosurgery, and to others as well as to orthopedic surgery. Physicians obviously want the best for their patients and to the extent possible they should have it. Here are just a few examples of state-of-the-art materials and their costs. This is a human thigh bone, the femur. The joints at each end of this bone are those most often requiring replacement with a prosthesis. The hip joint at the top of this bone is the more frequent one. Here is the metal substitute for the femoral part of the joint and here is the plastic cup that replaces the hip socket in the pelvis. They go together like this. Perhaps you would like to feel how smoothly they fit. As you move the parts think of a veteran free of pain. But the cost is over $2,000 a joint. At four per week $8,000 or nearly a half million dollars a year.

Incidentally this is the substitute for the lower condylar end of the femur at the knee joint, only slightly less expensive than a hip joint.

And that's just for starters. The disposable pump tubing and oxygenator required for a heart operation cost over $3.000 with each replacement valve going for $1,600. The weekly material cost for a minimal heart surgery program weighs in at $25,000 per week, well over $1,000.000 a year.

But it's only money.

In today's high technology environment these innovations come so fast that prospective budgeting lags far behind the real need. The VA's hierarchical bureaucracy is poorly structured to respond to the rapidly changing needs of this new order. One cannot but be concerned that proposed revisions in the budget process will be sufficient and on time. For example, the Agency's highly touted MEDIPP process, as the acronym defines, is referenced to the so-called "grass roots" of the VA Medical District. This focuses attention on the grass roots and the whole bureaucracy and the extent to which direct patient care professionals have an opportunity to apply their awareness and expertise to the most meaningful implementation of the Program.

In spite of promises and protestations to the contrary, in the leadership of the Agency's 172 Medical Centers, only five physicians are to be found as Facility Directors and so long as physicians serving in such important roles are denied Special Pay by administrative fiat that number will not increase. Only three physicians are to be found among the Agency's 28 District Directors and no physician is a Regional Director.

Of even more concern is the paucity of physicians to be found in the Agency's structured Leadership Program. In each year since its inception this program has accepted 60 applicants. In the beginning, 10 of the 60 were physicians, in 1979 only 9, in 1980 only 6, and this number was reduced to only 3 physicians in both the 1981 and 1982 classes.

It is clear that the valuable insights of the most critical of all the Agency's health care providers from the patient interface are not and will not be represented in its hierarchical bureaucracy unless positive changes are made.

Outside of the VA one must call on the other relevant Agencies and Departments of government to accept their responsiblities if the Nation's contract with its deserving veterans is to be honored. Aging hospitals have to be replaced by modern facilities at a greatly increased pace. Capital expenditures to implement the needs of modern medical technology must be increased. A classical example of this is the x-ray monitoring C-arm mentioned in this Report. It is equally useful for vascular and neurosurgery. They cost over $100,000 each. And lastly, but more importantly a sufficiency of qualified personnel must be provided to meet the health care needs of our aging veteran population.

I thank you on behalf of all those bind the wounds of war for the opportunity to express our concerns and to suggest the directions which need constructive exploration and treatment.

DAV

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

September 21, 1983

Honorable G.V. (Sonny) Montgomery
Chairman
Committee on Veterans Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Montgomery:

This letter is in reference to the forthcoming September 27 hearing to be conducted by the Subcommittee on Oversight and Investigations of the House Veterans Affairs Committee on the recent report compiled by the Committee on Veterans Administration of the Association of Orthopedic Chairmen.

Mr. Montgomery, we commend your decision to examine the above cited report.

As you have noted, the report sets forth a series of most critical allegations concerning the policies, procedures and practices of the VA's entire hospital system and its ability to provide quality medical treatment to veteran patients. If one is to assume that this assessment of VA health care represents the official opinion of the Association of Orthopedic Chairmen --and thus the opinions of the Departments of Orthopedics in medical schools across the entire country -- it is most essential to obtain further, more detailed information from the Association and to provide the VA's Department of Medicine and Surgery an opportunity to present its views.

The DAV is most anxious to observe the Subcommittee's public scrutiny of this report and we are certain it will be given a thorough examination. However, there is one area of the report which draws our special interest and I direct it to your attention in the hope that you might question the Association witness in the matter.

Page 20 of the report contains the following passage:

SYSTEM ENCOURAGES LONG, COSTLY, UNNECESSARY HOSPITALIZATION

> The VA hospital systems director, I believe, is to provide health care to veterans -- to treat the illnesses and return them to a well state

> or as close to it as possible. This is made increasingly difficult to do by legions of VA service representatives who wander the wards advising patients to "stay in for 21 days, then you will collect 100% disability." It is no small wonder we have to resort to "open threats" to send our patients home from the hospital that provides free bingo for cash prizes, movies, entertainment, tickets to sporting events, cut rate watches, radios, toiletries, clothing and cigarettes and a full time Diversion Therapy Department where they make gun cases, wallets and every other imaginable item for their own use at no cost. If we are to run increasingly busy "real hospital services" these negative incentives must stop. Somehow, it escapes me how constructing a model of the Battleship Iowa will help an injured patient more than valid vocational rehabilitation to help him return to the work force. 110

First of all I believe I am correct in assuming that the words "legions of VA service representatives" refer to or include those representatives of the various veterans organizations -- in the case of the DAV, accredited National Service Officers -- who daily visit VA hospitals in conjunction with their VA claims representation responsibilities.

If the report is alleging that DAV National Service Officers fully advise their hospitalized claimants concerning the extent of their benefit entitlement -- including the possible application of temporary, increased disability ratings due to hospitalization and/or convalescence for a service-connected condition -- than we stand "guilty as charged."

However, my question is this: Is the Association asserting that service organization representatives, or patients themselves, for that matter, are in control of and make decisions concerning hospital discharges? Are we to believe that attending VA physicians base their decisions to discharge a patient from the hospital on other than medical reasons? Also, we would be greatly interested in being apprised of the "open threats" that are made (to veterans?) in order to obtain a hospital discharge.

Mr. Chairman, we find this portion of the report to be confusing, misleading and, quite frankly, ludicrous. It leads me to state that the DAV views the entire "nature" of the report itself in a most unflattering light.

BEST COPY AVAILABLE

Upon examination, the report can only be categorized as a series of undocumented, disjointed charges and allegations, ranging from the serious to the trivial, made by persons who have chosen to remain anonymous.

We do not quarrel with the fact that the Association of Orthopedic Chairmen has chosen to publicly criticize the VA health care system. As you and your Subcommittee are well aware, the DAV has often found itself to be in a similar position. But we deeply regret the "unprofessional" manner in which the Association has chosen to air its views. In our opinion, the acrimonious nature of this report inhibits a thoughtful, cooperative dialogue on the part of all interested parties. It is counterproductive to serious investigation and not conducive to attainment of a goal that I am sure we all hold in common -- efficient, quality care for our nation's veteran population.

Mr. Chairman, I appreciate your attention to this letter and respectfully request that it be included as a portion of the September 27 hearing record. I look forward to the Subcommittee's hearing on this most important issue.

Sincerely yours,

JOHN F. HEILMAN
National Legislative Director

JFH:bc

cc: Congressman Hammerschmidt

STATEMENT BY

CHARLES A. ROCKWOOD, JR., M.D.

CHAIRMAN, DEPARTMENT OF ORTHOPAEDICS

UNIVERSITY OF TEXAS MEDICAL SCHOOL

SAN ANTONIO, TEXAS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

SEPTEMBER 27, 1983

Mr. Chairman and members of the Committee, my name is Charles A. Rockwood, Jr., and I am here testifying as the Chairman of the Department of Orthopaedics of the University of Texas Medical School and Health Science Center in San Antonio, Texas. I have been the Chairman of Orthopaedics since 1966 and have had a chance to watch the building of the Audie Murphy VA Hospital, which is now physically connected to our teaching hospital.

Our teaching faculty and residents are responsible for a large number of patients at the VA Hospital in that we see over 11,000 outpatients per year, have a 40-bed inpatient service and utilize between 15 and 20% of the operating room time. I personally see patients in the specialty orthopaedic clinic and perform surgery in the VA facility on a weekly basis. Therefore, I can personally attest to the quality of our VA Hospital.

We are indeed fortunate in having a superb Chief of Staff and Hospital Director in Dr. Tom Newcomb and Mr. Jose Coronado. These men provide a considerable amount of service. In addition, we have excellent personnel in our clinic staff, cast technicians, nurses and secretaries. We also have all of the necessary, current state-of-the-art operating room instruments, equipment and implants for fracture care, joint reconstructions and total joint replacements.

Our faculty is responsible for the total care of the orthopaedic patient and we recognize that our VA Hospital offers an excellent addition to our Health Science Center for medical student and resident education. However, we do not live in a utopia at the VA Hospital nor for that matter in our teaching hospital, and as such there are some rough spots in both institutions. I dare say that most hospitals in the country do have resource and staffing problems of one type or another. These problems are often the result of patient demands and of a society that is growing older.

I believe that the VA is currently encountering a problem that will grow into a major crisis over the next 15 years; namely, the problem of meeting the medical care needs of the aging veteran. In 1990, because of the increasing longevity of the veterans, there will be 7.2 million veterans over the age of 65 and by 1995 there will be 8 million or almost 60% of all American men in that age group. These figures indicate that there will be a tremendous increase in patient care activities for the Veterans Administration hospital system. Of particular interest to the orthopaedic community is that the increase in the number of aging veterans will mean a substantial increase in the number of patients with orthopaedic problems. It should be noted that at the present time, six of the most common service-connected disabilities diagnoses are orthopaedic problems.

I believe, however, that the central office of the Veterans Administration is fully aware of this future shock problem and is trying to plan for the increase in the work load. For example, in August 1981 they issued a circular concerning the "Establishment of New Physician Directed Patient Care Services." To me this indicates that they are willing to be adaptive and innovative in order to meet the need of this Nation's veteran.

In summary, Mr. Chairman, let me say that in San Antonio the Audie Murphy VA Hospital enjoys an excellent reputation and works in close harmony in its affiliation with the University of Texas Health Science Center. We deliver first class orthopaedic care to the veterans and look forward to expanding our working relations in order to meet the orthopaedic needs of the aging veteran.

Thank you for inviting me to testify on this important matter. I will be happy to answer any questions.

STATEMENT OF ROBERT E. LYNGH, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
TO THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
SEPTEMBER 27, 1983

Mr. Chairman and Members of the Subcommittee:

The American Legion is pleased to have this opportunity to place in the hearing record its views with regard to the document titled "Report Of The Committee on Veterans Affairs Of The Association Of Orthopedic Chairmen." The Report is dated July 1, 1983. It states that all those who contributed to the report are orthopedists working within the VA Department of Medicine and Surgery.

Let us first state that The American Legion is both entitled and competent to present its evaluation of the report because it is the largest veterans service organization in the nation, and thus is a bona fide consumers' representative. Further, The American Legion is, to our knowledge, the only service organization at the present time that maintains a Field Service staff that makes regularly scheduled visitations to VA medical centers and clinics for the purpose of observing and reporting on the quality and timeliness of care provided to veteran patients. During calendar year 1983, the Legion will accomplish site visits to 65 VA medical centers. These site visits include conversations with administrative and professional personnel, and with patients and patients' families. Our site visit reports include recommendations that are forwarded to a full range of interested persons and organizations, including the Committees on Veterans Affairs of the Congress. We believe the extent of our membership and our field service qualifies us to speak authoritatively, as interested laypersons, to the present condition of the Department of Medicine and Surgery, and the care it is providing to veteran patients.

Speaking directly to the report that is the subject of this hearing, The American Legion wishes to state categorically that it rejects the validity of any report that is made up of allegations, innuendoes and charges offered on an anonymous basis. The way things are done in this country, if anyone has a complaint about the way our Government, or any element thereof performs, such person should come forward and state the complaint so that it can be responded to, and dealt with in straightforward fashion.

We must say that a report such as this one, coming from a professional organization is demeaning to the ethics and standards that are supposed to govern the activities of professional people.

The instances included in the report are for the most part anecdotal and demonstrate a fundamental lack of understanding of how a government agency can and must operate. Such agencies, including the VA do not have the flexibility and freedom to make easy adjustments in operating procedures, as can be done in non-governmental activities. There is no question the bureaucracy is cumbersome and slow to respond. That fact is a constant frustration to all citizens who do business with their government. But it was ever thus, and those who work within the bureaucracy are expected to perform their duties in the best manner possible within the limitations imposed by the very nature of government.

The American Legion would be the first to say there are many problems today in the functioning of the health care system operated by the VA. We constantly try to bring problems to the attention of the VA and of Congress, to seek remedies and improvements. The VA health care system - the largest, comprehensive integrated health care system in the nation - is replete with problems, as we have said. It is also true, to our factual knowledge that the system, on a daily basis, provides high quality medical care to thousands upon thousands of sick and disabled veterans. Lives are saved, pain and suffering are alleviated, some of the most advanced research in the nation is ongoing, and some of the finest medical education is provided to health care professionals.

This system does not need to be basically restructured and reorganized. It needs an adequate supply of funding, and it needs constant attention from both within and without its ranks, to solve the problems that do exist, toward the goal of making the system as cost-effective as possible while providing ever higher quality care to the maximum number of eligible veterans.

The allegations, charges and innuendoes included in the report are not only unworthy of those who make them on an anonymous basis, but they even call into question whether the accusers understand the lines of authority and the operational procedures that prevail in any hospital or clinic, be it governmental or non-governmental.

For instance, many of the allegations and charges made in the report involve things that can be handled through the simple process of following standard hospital procedures. Every surgeon reports to a chief of service, who has access to the Chief of Staff, who has access to hospital management. Such things as provision of needed equipment and supplies and scheduling of OR time are dealt with constantly in all hospitals. Good line and staff communication can serve to overcome most problems. If an emergency is not dealt with because the system breaks down and there is resultant permanent injury or loss of life of a patient, an investigation should follow and heads should roll. No physician should tolerate less in the hospital in which he practices. The American Legion moves aggressively in every instance in which we become aware that the system is not functioning properly. If we cannot get satisfactory response from the VA, we go to the Congressional Committees that oversight the VA, and those Committees always respond to our petitions. How can a physician be in VA service and not be familiar with these rudimentary facts?

It is clear to us of the Legion, that in addition to its other failures the report in question demonstrates the most obvious kind of parochial perspective - in other words - let's place orthopedics at the head of the list of concerns - regardless of all the other disciplines and services that make up the range of functions of a modern hospital. In our judgment, these unnamed orthopedists should be ashamed of themselves for putting all of this material in a public report and then presenting it to the Congress of the United States. It certainly does not measure up to their presumed professional stature.

While we are not going to address in detail the number of charges in the report, we will mention one or two we find particularly galling. We refer to comment that surgical equipment is lacking while parking lots are paved, and another that patients are kept in the hospital, playing bingo so that their compensation will be increased.

Any person who works with or within the government, knows or should know the basic methodology that is followed in federal budgeting and appropriations. VA cannot willy-nilly transfer moneys appropriated for physical improvements to the purchase of equipment and supplies. And those who work as intimately in DM&S as do physicians, know, or should know, that because of technicalities involving eligibility and the requirements of government standard delivery of care, patients cannot always be processed, treated and discharged as easily as can be done in private sector medical facilities. As we say in the vernacular, these orthopedists should wake up and smell the coffee and find out what is going on around them.

Mention is made of the absence of outpatient surgery, which is an increasing modality used in the private sector. It is not as easy for VA to employ this modality due to variations in eligibility for various categories of patients. However, we of the Legion are aware that some VA facilities are developing outpatient surgical capabilities - at least to a limited extent. One that comes to mind that we have seen personally is the new outpatient surgery at VAMC San Juan, Puerto Rico - one of the busiest hospitals in the system.

Also, we of the Legion can attest that DM&S has, in fact, made a good faith effort during the past several years to shorten length of stay for patients in the VAMCs. This is an ancient criticism that the opponents of VA health care have thrown at the agency for years.

It has been patiently explained to all and sundry that private sector hospitals are gauging length of stay in acute care facilities, whereas LOS for VA includes psychiatric, nursing home care and domiciliary facilities which inevitably have longer LOS. So there is no true comparison. If the orthopedists who work within the VA system don't know this - which their observations would indicate - our question to them is why don't they know it?

We hope the statements and observations offered herein to the Subcommittee will make clear that The American Legion rejects the Report of the Orthopedic Chairmen out of hand. It is neither a factual nor a professionally valid document in our judgment, and essentially, it provides no help to the Congress in evaluating and seeking improvements in the VA health care delivery system. Our recommendation is that the Committee on Veterans Affairs should spend no more time on it.

If a current evaluation of the entire VA system is indicated at this time, The American Legion will be happy to cooperate with and lend its support to such an evaluation undertaken by a Congressional Committee or by a designated health care authority selected by the Committee on Veterans Affairs for this purpose. We have no doubt such an evaluation would find things that need to be corrected or changed in the present VA system. We would most certainly trust the Committee to develop a suitable plan of action to accomplish changes and modifications, designed to improve cost-effectiveness as well as quality of care for veteran patients.

We thank the Subcommittee again for receiving our views.

○